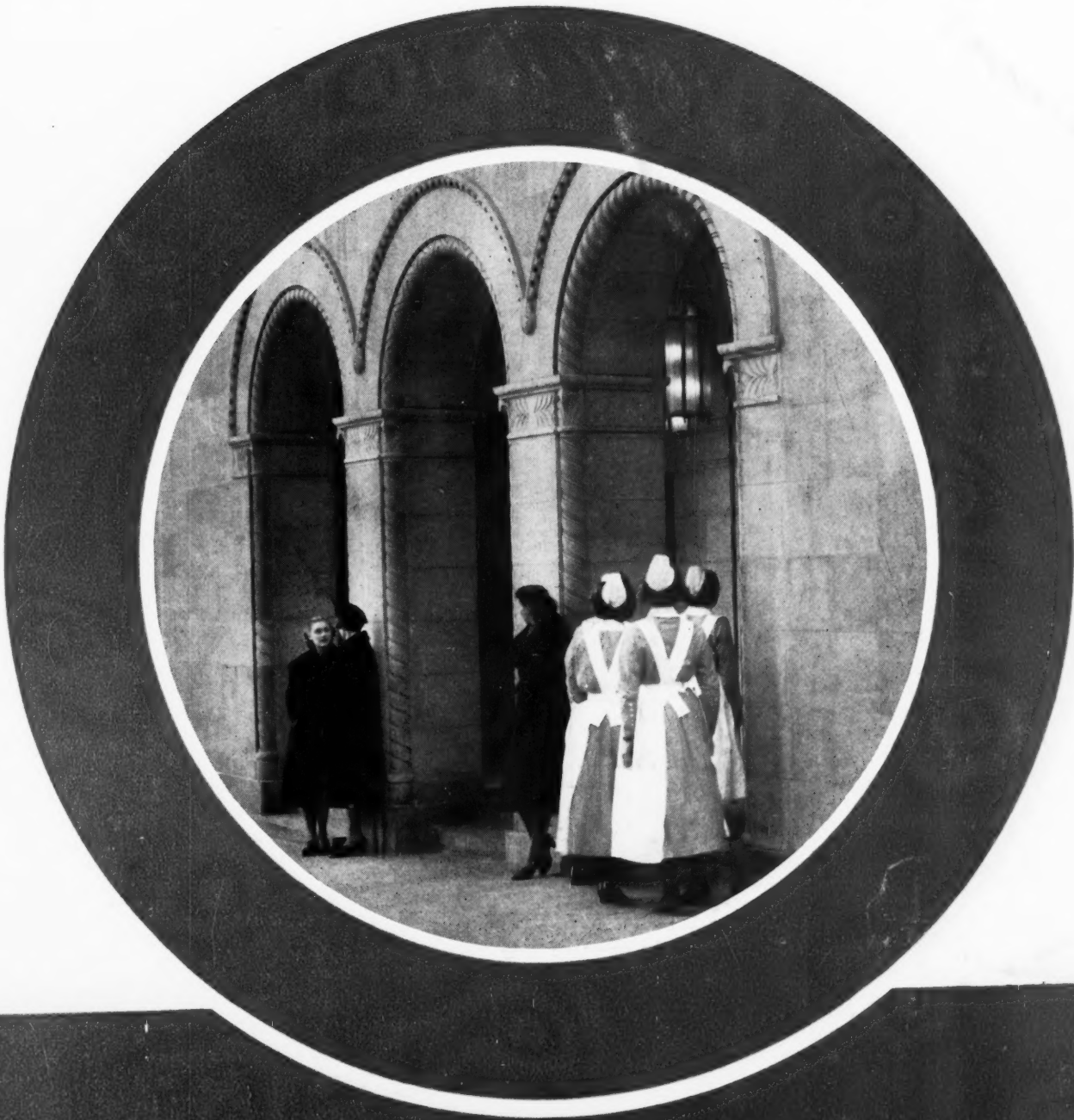


Hospital Library

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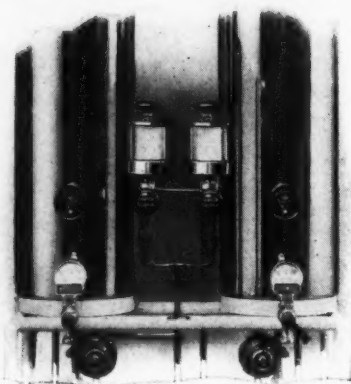
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MODERN
HOSPITAL

VOLUME 53

AUGUST 1939

NUMBER 2

Sensational DEVELOPMENTS AND IMPROVEMENTS PROVE CASTLE LEADERSHIP



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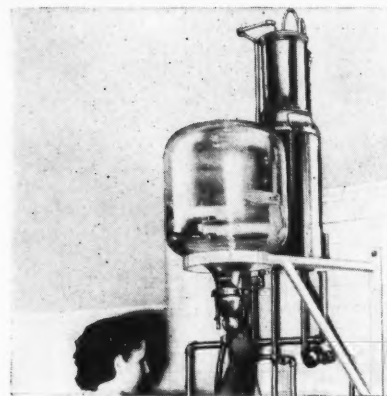
The Humidicrib provides a scientific control of humidity and temperature thereby maintaining a proper balance between loss of heat and production of heat in premature, as well as full term infants who are not gaining as they should.

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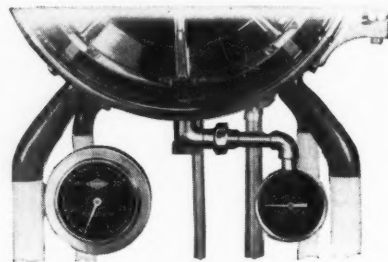
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MANY of the country's leading hospital administrators have taken seriously their obligation to the generation that will follow them. Young men and women eager to train themselves for hospital administrative careers have been accepted as apprentices. In a few instances, the apprentices have previously taken specific university preparation for the administrative career. Far more frequently, however, their preparation has been in medicine, nursing, business administration, social service or some other related field. Many of today's outstanding administrators received their training in this way.

If such an administrative internship is to be of the most value, however, it ought to be carefully planned and well integrated. An administrator cannot afford to take apprentices unless he is willing to give considerable time, thought and effort to their education. The nature and content of a good internship have been outlined for the American College of Hospital Administrators by Dr. Claude W. Munger, director, St. Luke's Hospital, New York.

Doctor Munger's suggestions will be published in *The Modern Hospital* next month. It will be of interest to every person who is concerned in any way with the development of present day standards of education for hospital administrators.

THE cover on the July issue showed an attractive vine covered hospital in a park-like setting. The uninformed might surmise that this was just a sleepy New England institution resting gracefully on past laurels and on traditions. How wrong he would be! Behind that quiet exterior is found one of the most dynamic community hospitals in the country. Next month Robert N. Brough, administrator of the Norwalk General Hospital, Norwalk, Conn., will reveal the progressive steps that his hospital is taking to keep itself abreast of community needs.

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WHAT responsibility does the operating room supervisor have to control costs in her department? How can she know what the costs are for the activities under her jurisdiction? An excellent system for determining and controlling costs in the operating room has been worked out at the University of Chicago Clinics and next month Nellie Gorgas, assistant to the administrator, will describe it in full.

WHO owns the radio waves? For what purposes should the various bands be used? When the electrical therapy equipment in the hospital interferes with radio transmission what steps can be taken to avoid serious clashes? This is no academic question but one of real significance to hospitals and physicians. Next month Dr. H. B. Williams of Columbia University, who knows this problem both as a physician and a physicist, will outline practical steps to minimize what may develop into a heated conflict.

WE ARE more than proud of one member of our editorial board this month. When you read the program that he has prepared for the International Hospital Congress in Toronto, you will be proud of him, too. For Doctor MacEachern belongs to you as much as he does to anyone. He has dedicated his life to the whole hospital field and each one of us can claim a share. Incidentally his program appears on page 66 of this issue. If you read it, we shall be pretty sure to see you in Toronto.

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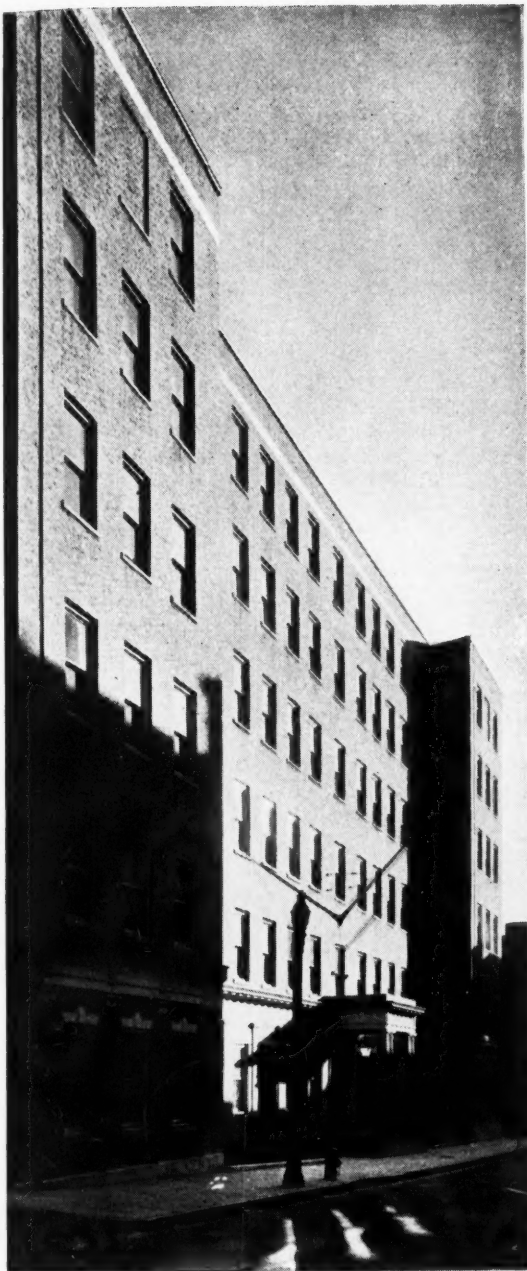
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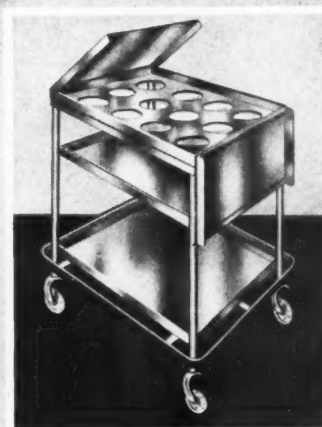
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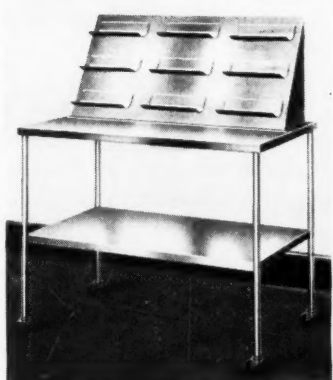
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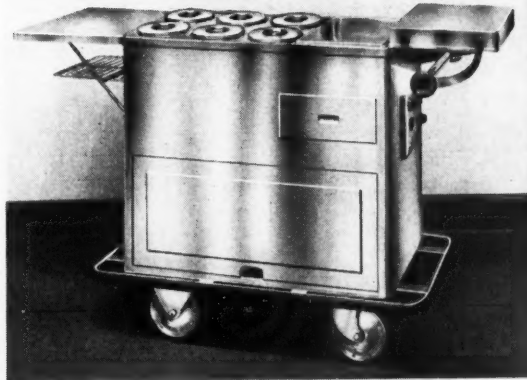
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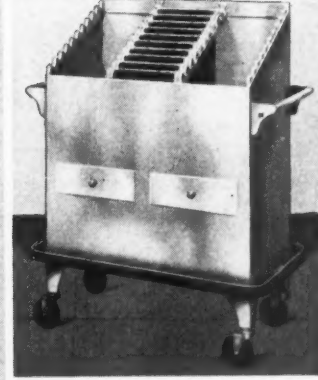
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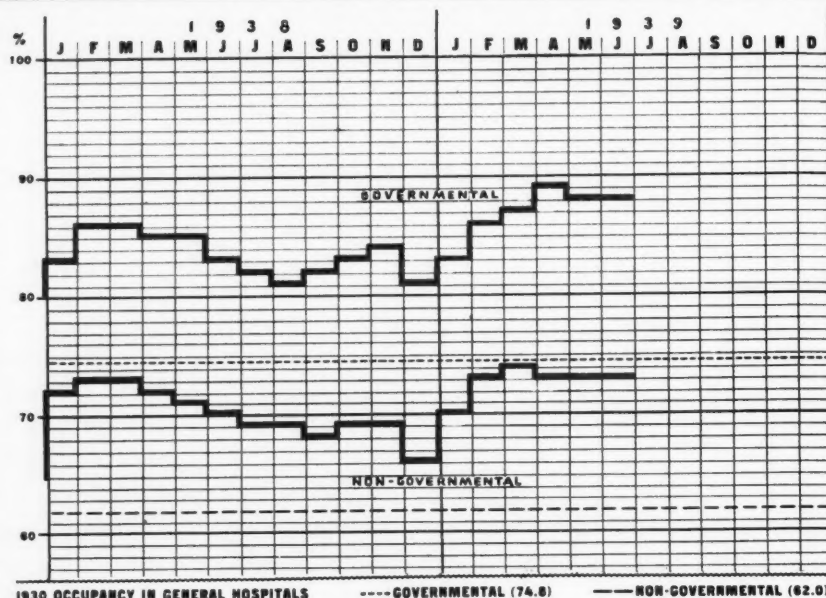


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HOSPITAL OCCUPANCY BAROMETER

Type and Place	Census Data on Reporting Hospitals		1939		1938	
	Hosp. ¹	Beds ²	June	May	June	May
Government						
New York City.....	17	11,027	102	106	99	103
New Jersey.....	4	2,122	93*	93*	88	91
Washington, D. C.....	1	1,220	70*	70*	70*	70*
N. and S. Carolina.....	19	2,102	73	69	72	70
New Orleans.....	2	2,466	113*	114	96	97
San Francisco.....	3	2,255	90	92	87	88
St. Paul.....	1	850	70*	70	66	72
Chicago.....	2	3,500	90	91	87	87
Total³.....	49	25,542	88*	88*	83*	85*
Nongovernment						
New York City ⁴	68	15,194	77*	77*	73*	77
New Jersey.....	62	9,772	78*	78*	68	69
Washington, D. C.....	9	1,818	72*	72*	72*	72*
N. and S. Carolina.....	104	7,103	69	66	66	66
New Orleans.....	7	1,176	73*	68*	74	73
San Francisco.....	16	3,178	76	75	71	69
St. Paul.....	9	1,150	72*	72	69	70
Chicago.....	13	2,328	63	68	64	65
Cleveland.....	6	920	80	79	76	75
Total⁴.....	294	42,639	73*	73*	70*	71*

¹Excluding hospitals for tuberculous and mental patients and institutional hospitals. Census data are for most recent month. ²Including bassinets, usually. ³General hospitals only. ⁴Occupancy totals are unweighted averages. ⁵Preliminary report. Complete occupancy figures for January, 1933, to October, 1938, are given on page 798 of The Seventeenth Hospital Yearbook.



Hospital Business Having Banner Postdepression Year

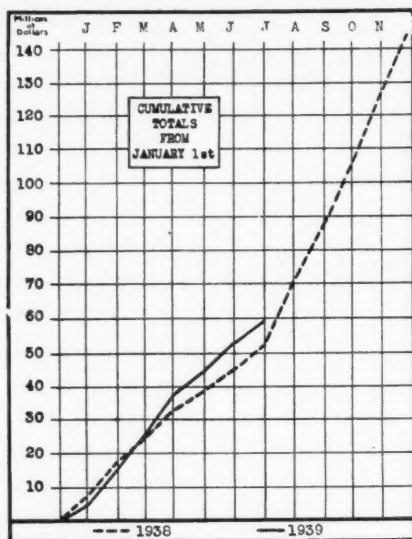
Voluntary hospitals continued to report a high occupancy for June, thus maintaining for three consecutive months the figure of 73 per cent. These figures are still preliminary and subject to some adjustment but, if not decreased by later reports, they indicate that hospital business is two or three points above the situation of a year ago. Occupancy now equals or exceeds the reports for 1937, which heretofore has been the banner postdepression year for voluntary hospitals.

For the first six months of the current year the average occupancy in the nongovernmental general hospitals was 73.4 per cent. Last year the comparable figure was 71.7 per cent and, in 1937, it was 72.8 per cent.

Occupancy in the government general hospitals also is stabilized at a high level. The reported figures are 88 per cent for June as well as for May. Last year, the occupancy was 83 and 85 per cent for these two months. For the first six months of 1939 the occupancy in these hospitals was 86 per cent. In 1938 the figure was 85 per cent and in 1937 it was also 85 per cent.

The continued high occupancy in both government and nongovern-

HOSPITAL CONSTRUCTION



ment hospitals apparently indicates that both pay patients and those who cannot pay are increasingly desirous of utilizing the facilities which hospitals provide.

New hospital construction reported during the month totaled nearly \$6,800,000. This brought the total

amount reported since the first of the year to \$59,140,000 as compared to \$52,000,000 at the same time last year. In the four weeks ending July 17, there were 58 new construction projects reported of which 56 gave costs totaling \$6,772,850. There were 11 new hospitals to cost \$1,326,000. Additions to existing hospitals totaled 43 of which 41 reported costs of \$5,141,850. Four new nurses' homes were announced to cost \$305,000.

Wholesale prices as reflected in the *New York Journal of Commerce* index rose somewhat during the four weeks ending July 15 but fell again in the last week. Grain prices dropped consistently during the period, the index number going from 60.1 to 54.9. Food prices, on the contrary, went up from 63.7 to 66.0. Textile and fuel prices remained practically unchanged, the former at 57.9 per cent and the latter at 84.1. The price of building material took a small tumble from 98.0 to 95.8, the first time these prices have fallen significantly in nearly a year. The price index for drugs and fine chemicals of the *Oil, Paint and Drug Reporter* showed a slight decline from 183.1 to 182.7.



Build **CONFIDENCE** Here ...with *Crane-Equipment*

PROBABLY in no other part of the hospital is public confidence so vital as in the nursery. For the nursery must be above suspicion. Crane-Equipment in the nursery goes a long way to establish the confidence on which modern hospitals depend.

In the design of Crane Infant Baths, no detail has been overlooked that contributes to safety and convenience in use. Crane Infant Baths are easy to keep clean and offer positive protection from dangerous back siphonage. They are designed with convex drain slabs—extra

deep to prevent slopping of water on the floor. A ledge keeps the infant from sliding into the basin—yet permits rapid drainage. There are other safety features such as balanced-type mixing valves and thermostatic water temperature control.

Like all Crane-Equipment, Crane Infant Baths are built to stand up under hard hospital usage. Get complete facts about Crane plumbing equipment. Use your Crane Hospital Catalog, and ask about the Crane Budget Plan for hospital modernization.



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Solves Visiting Problem

• After three years of observation and experimenting Everett W. Jones, director of the Albany Hospital, Albany, N. Y., has established a routine for visitors that should meet this problem for good and all. It is embodied in an attractive little folder "A Message to the Visitor." On the first page are such suggestions as:

"Rest, quiet and freedom from worry are as essential for your relative or friend as the treatment prescribed by the doctor, and so we remind you that staying overlong may hinder the recovery of the patient.

"The hospital is doing its part to protect your relative or friend by establishing regular visiting hours and by limiting the number of visitors who may come in at any one time. Please do your part.

"Children are far more likely to be carriers of contagious and communicable diseases. Also because of their greater activity they are noisier than adults. Accordingly, we do not allow children under 14 years of age to visit anywhere in the hospital.

"Please do not bring food to patients except by permission of the head nurse; if you bring any, limit the amount to that which the patient can eat within the day it arrives.

"If you have a cold or have been near someone who has one, delay visiting your relative or friend in the hospital as he may contract it and have his recovery materially delayed."

On the inside pages of the leaflet are detailed rules for visiting each department. Visitors who come to see relatives or friends in semiprivate rooms or wards must first obtain visitors' cards; only two guests may visit the patient at one time; visitors must have a pass if visiting outside regular hours.

It is urged that morning visiting of private patients be limited to members of the patient's immediate family, and it is recommended that as few relatives as possible visit during these hours. "Any visiting at all during the busy morning hours interferes with the proper care and progress of the patient. The hours from 1:00 p.m. to 2:30 p.m. are reserved for the patient's rest period. As a general rule, patients have too many visitors for their own good. We suggest that the number of visitors at any one time be limited to two."

The same provision applies to the maternity department with this additional recommendation: "We urge that visiting during the first week following delivery be restricted to members of the patient's immediate family. Even after the first week we suggest that visitors be kept to an absolute minimum."

Parents who are visiting children in private rooms in the pediatric department are urged not to stay or request permission to stay during any time other than the regular hours, *i.e.* 10:30 a.m. to 1:00 p.m., and 2:30 p.m. to 4:30 p.m. "In addition to the mother who may be staying with her child, two visitors will be permitted at one time. Long experience with many children of all ages, dispositions and degrees of illness has convinced us that almost without exception routines necessary for the progress of the child can best be carried out when parents are not continually present."

The entire plan is just as explicitly explained to information and visiting card clerks, visitors' monitors, doctors and nurses and other hospital employees.

"All of us must remember that our work brings us in contact with many worried, excited and often unreasonable people. We should at all times be firm but in a pleasant and courteous manner. We must never antagonize our guests. Our visiting rules are made to protect the progress and well-being of our patients."

London's Latest

• Your Roving Reporter has taken a trip through the new Westminster Hospital, London, with the *London Times* as his guide. Westminster Hospital is 220 years old but its new plant is as modern and as British as its designers could make it. So far as is possible in construction and equipment it is all British.

In the private patients' section great use has been made of woods. The visitors' lounge is paneled in weathered sycamore and Australian oak. The furniture is weathered sycamore reminiscent of the 18th century in design.

In the private patients' rooms all walls are decorated in a pale primrose color but the draperies, rugs and other decorations have been built up to harmonize with the various woods used in the furniture. These are: Australian walnut, oak, honeywood, Australian

silky oak, French walnut and African cherry.

For the wards four color schemes have been employed. A different color for dividing curtains, bedspreads, towels and china has been selected for each of the three or four departments on each floor, for convenience in issuing and checking supplies.

A new decorator's fabric, a mixture of linen and cotton, in a design exclusive to the hospital, has been selected. It is preshrunk and color-fast to light and to boiling. This material has been used throughout the hospital except in the private rooms. Cubicle curtains run on a track of anodized aluminum of new design and exceptional strength. Runners are silent and fixtures are designed for easy cleaning.

Volunteer Book Binders

• Volunteers are exceptionally active in London hospitals, it appears. Your Reporter likes the idea of the volunteer book repairers who resew and rebind books that are beginning to break up in the hospital library. In the Westminster patients' library one section is kept rigidly apart. It is used for cancer patients and for some skin disease patients. The books are chiefly paper backed so that, if need be, they can be destroyed without much loss.

War Precautions

• As London now lives under the shadow of war, a special detail in the design of Westminster Hospital is its protection against air attack. As far as incendiary bombs are concerned, protection has been provided by a 6 inch layer of concrete over the whole area of the roof and the two floors below.

Against the more serious menace of high explosive bombs, arrangements have been made to stiffen the lower floors and basement so that they can support the whole weight of the building should it threaten to collapse.

The extra strength is provided by a number of tubular steel struts with a screw jack end. The places between the ceiling and the floor where they must go carry permanent marks and the struts are marked and grouped for each room and kept in a special storage space. If the need arises they can be easily and quickly placed in position by the hospital staff or by any labor available at the time.

LOOKING FORWARD

Tragic but True

IT IS ironical as well as tragic that some hospitals have neglected so long the problem of controlling the spread of tuberculosis among their personnel. Elsewhere in this issue, the problem is vigorously discussed by Dr. M. Pollak, medical director of the Peoria Municipal Tuberculosis Sanitarium of Peoria, Ill. Doctor Pollak is not a professional viewer-with-alarm. Yet he is definitely concerned about the present situation.

How can hospitals hold up their heads in the community if, by failure to take proper steps, they actually spread tuberculosis to their student nurses, interns, residents and employees? How can they safeguard the health of their patients if the people who serve those patients may unknowingly infect them?

Next month Dr. William E. Ogden of Toronto and his colleagues will describe a new technic for detecting tuberculosis that has effectively safeguarded nurses and others at Toronto Western Hospital. In the face of the facts presented by these two articles, every alert hospital will wish to give immediate attention to this problem.

Fortunately, there has just been published by the council on professional practice of the American Hospital Association a manual by Dr. William H. Oatway Jr. on "The Management of Tuberculosis in General Hospitals." Doctor Oatway states that no hospital in the entire country has in operation a complete program for the recognition of the disease, the observance of precautions while diagnosis is pending, careful custody of diagnosed cases and repeated determination of the tuberculous status of the employees and staff members. He outlines carefully the major points in such a program.

New National Council

THE formation on June 24 of the Advisory Council on Medical Education marks another forward step in the coordination of the efforts of various organizations concerned with this important field. It also signals the importance that hospitals have come to

have in the training of physicians. Five of the 25 representatives on the council are appointed by the three national hospital associations.

Dr. Willard C. Rappleye, dean of the faculty of medicine of Columbia University, who was elected president of the council, states that its purpose is to correlate the efforts of the universities, medical schools, hospitals, licensing bodies, public health associations and boards of specialists. He points out that this organization brings together for the first time the various national bodies dealing with all phases of the training and licensing of physicians from preparatory college work to graduate training for specialization. "Cooperation and coordination," he declared, "are to be substituted for present overlapping and competing functions of existing agencies."

The new council now includes representatives from 13 national agencies directly concerned with medical education. Other organizations that have been invited to accept membership may do so at a later time.

For many years there has been a feeling on the part of some hospital leaders that hospitals were being told what they must do without much opportunity to counsel and advise concerning the standards to be enforced. It is gratifying, therefore, that the new national council brings hospitals into membership on the ground floor.

Qualified Dietitians

THE American Dietetic Association some years ago set up educational qualifications for dietitians and an inspection and approval program for hospitals and institutions giving practical training following the academic work. The requirements at present are: (1) a bachelor's degree with a major either in foods and nutrition or in institutional management or a bachelor's degree followed by enough courses to complete a major in either of these subjects plus (2) at least two years of "successful" experience in a hospital, cafeteria, hotel, educational institution or commercial or publishing agency. Satisfactory completion of a course in applied nutrition or institution management or publication of original research in these fields may be substituted for

the practical experience. A loophole is also left for "other especially qualified persons whose applications have been approved by the membership committee" and by the association's executive board.

A directory of approved training programs published last December included 51 hospital courses, four administrative courses in colleges and universities and one food clinic course. According to this directory there are 428 students in the hospital courses, 27 in the "administrative" courses at universities and three in the food clinic course.

Thus, a total of 400 to 500 new dietitians is available each year. Since these new dietitians constitute about 10 per cent of the total number of dietitians who are members of the American Dietetic Association, it would appear that the number being trained would come reasonably close to meeting the demand.

In recent years hospital administrators and medical staff members have gained an even clearer realization of the importance of food, therapeutically, psychologically and economically.

The American Dietetic Association recently requested the American Hospital Association, the American Medical Association and the American College of Surgeons to endorse the standards set up by the dietitians and to accept their inspection and approval of hospital courses. They pointed out that there are several proprietary and other trade schools claiming to train dietitians in less time, even in periods as short as one year, and that such dietitians tend to lower the standards of food service in hospitals.

In view of the importance of dietetics in the hospital and of the apparently ample supply of well-trained dietitians available, it is probable that all well-administered hospitals will wish to employ only competent dietitians in their food service departments. It would be wise, however, for the dietitians to attempt to gain this objective by persuasion rather than by force and to counsel with authorized representatives of the hospital field at each step of the way.

The Crux of the Matter

SOME believe that staff men are poor disciplinarians of the members of their group and yet it cannot be doubted that self-government on the part of the staff is to be seriously sought. Under our present hospital system the maintenance of technic, the checking of postoperative results, the searching for the cause of crossed infection and the checking of postmortem findings with antemortem diagnoses are placed in the hands of the surgical conference or staff committee.

It matters but little how splendid the administrative setup, how stately the buildings housing the sick or of what high reputation is the staff individually and collectively if the patient loses his life because of a lack of supervision of the efficiency of the operating room or

the medical wards. There must be some continuing influence that refuses to accept the presence of a fever in the maternity as the usual thing. It is necessary for someone to discuss seriously a repeated surgical accident on the part of a staff member. From somewhere must come a searching inquiry into the reason for infant morbidity or mortality.

Persons must not be spared. Too often the feelings of the surgeon, the obstetrician or the internist take precedence over the welfare of the patient. Too frequently the policy of "what happened has happened" is adopted. The crux of the whole matter of the care of the sick lies not in the physical but in the scientific care of the patient. Unless there is a fearless, fair supervision of medical care of patients which is not content to leave any stone unturned in the search for causes of accidents and which elevates principles to a much higher plane than persons, the welfare of the individual hospital patient will be in jeopardy.

Lack of Standardization Costly

SURGEONS are routinely individualists. Their psychology, of necessity, manifests itself in a meticulous attention to detail. This trait frequently is expressed in such apparently unimportant matters as a slight variation in the size of gauze dressings, drainage methods, scrubbing, draping and gowning procedures. The obstetrician likewise insists upon the necessity for the most intense attention to the small things that from time to time if neglected can endanger patients' lives.

No one would endeavor to change this psychology. It is necessary, and represents the various links that make up a strong antiseptic chain. But there is little reason to justify the confused state of affairs that is to be found in many operating and delivery rooms. It is impossible for nursing staffs to be properly trained in the carrying out of a dozen different technics, all of which are basically sound but which in every instance differ in minor details. Errors creep into the activities of the nurse when she is endeavoring to adjust her memory to the service of each obstetrician or surgeon.

It is high time for the medical staff to retain essentials, to discard petty individual insistence on details and to agree upon a standard method of preoperative and postoperative care.

The Intern's Health

IT SEEMS to have been accepted as axiomatic by hospital administrators that members of the intern staff present no health problems and that the physical check routinely afforded to nurses does not apply to this group. Every now and then, as a result, an intern breaks down during his institutional life because of a health handicap that should have been discovered upon his entrance.

In a large medical school in the East, a careful chest examination revealed an alarmingly large number of medical students suffering from tuberculosis. Indeed, it has been but a few months since an intern staff in a county institution became so phobic over the possibilities of contracting tuberculosis that as a body it requested to be excused from a service in these wards.

The young physician comes to the hospital after having undergone four years of the most strenuous mental and physical activity. His weight is often at a minimum and usually no rest period intervenes between graduation and hospital service. It seems only fair to subject the new intern to a careful physical checkup. This should include not only the ordinary skin testing for susceptibility to diphtheria and scarlet fever but also an x-ray examination of the chest, a full blood count, a blood chemistry analysis and a urinalysis. Half way through his course, a part or all of these procedures should be repeated.

If the hospital practices preventive medicine in its intern group, one will hear less often of young physicians who during their first year of practice require long periods of treatment to restore their health and usefulness.

New Bedfellows

ON JULY 1, the United States Public Health Service was transferred by presidential order from the Treasury Department to the newly formed Federal Security Agency. Thus was brought to a close an association between this service and the fiscal arm of the government which had existed for nearly 141 years, only nine years less than the full life of the nation itself under the constitution.

Speculation as to the significance of this transfer could easily run to wild extremes. In its new home the Public Health Service will find as companions the United States Employment Service, the Office of Education, the National Youth Administration, the Civilian Conservation Corps and, most important of all, the Social Security Board. These agencies are the ones which, in the President's words, have as their major purposes the promotion of "social and economic security, educational opportunity and the health of the citizens of the nation."

The Public Health Service and the Social Security Board are not strangers. Through the Interdepartmental Committee to Coordinate Health and Welfare Activities, they cooperated in the formation of the national health program. Their closer affiliation through the Federal Security Agency will probably signify an even greater interest in the social as distinct from the purely technical aspects of public health. Ever since Doctor Parran was appointed surgeon general of the service, it has been moving in this direction. Such movement will probably be continued and may

even be accelerated. This will mean that the service will have increasing contact with voluntary and governmental hospitals.

A Mayo Passes

AFTER fifty-one years in the practice of medicine and surgery, in the course of which his own and foreign governments gave him coveted honors, universities throughout the world bestowed degrees on him and scientific societies elected him to their highest offices, the life of that great man, Dr. Charles Horace Mayo, ended on May 26, 1939.

Doctor Mayo's position in surgery, his contributions to education, especially to postgraduate medical education, and his stimulating participation in the field of public health are well known. His interest in hospital problems was equally enduring although, perhaps, not so widely recognized. He was a member of the committee on medical schools and hospitals of the American Branch of La Bienvenue Française and of the International Hospital Association.

The presidential address of Doctor Mayo before the Sixth International Congress on Tuberculosis, in 1908, was partly on hospital construction. This was a subject he knew well, for he had taken a large share in the building and development of St. Mary's Hospital. In this work, particularly in the construction of the elevators and the water system, Doctor Mayo made use of the mechanical bent which also came into play when he designed the first operating table used in St. Mary's. In a discussion of a paper by Dr. C. L. Greene, in 1911, Doctor Mayo gave briefly the results of some of his thinking concerning the function of a university hospital. In other addresses given in 1914, 1921 and 1926 he expressed his interest in the hospital as an educational institution, in the nursing care available in the hospital and in the community hospital.

His last paper dealing with hospital subjects was written with his son, Dr. Charles W. Mayo, and was contributed to *The Modern Hospital* in 1938. Concerning surgery's problems as they affect the hospital, the authors wrote: "The changes that have taken place from a mechanical standpoint, as in instruments, surgical lights, operating tables—one could go on indefinitely—have added to the responsibility of the surgeon and the hospital. . . . The problem of education, not only of the future surgeon but also of the surgical nurse, falls in the lap of the surgeon and the hospital. These are obligations which cannot be shunned and which, in fact, should be welcomed for the service they render. . . . We can be justly proud of achievements that have been made in the orderly cooperation of all those groups of people whose first thought has been, is and will continue to be the welfare of the patient." In these few sentences are reflected the guiding principles and the confidence in the future of Charles H. Mayo.

Do Our Hospitals Actually

IT WOULD be natural to expect medical colleges, hospitals and schools of nursing to be in the front of the battle against tuberculosis. One would expect that these institutions, to which is entrusted the education of our future physicians and nurses, would utilize present day knowledge in the diagnosis of tuberculosis to protect their young charges from the ravages of this disease. Yet in a recent admirable exposé entitled "Tuberculosis Among Children and Young Adults," Dr. J. A. Myers comes to the conclusion that "our schools of nursing and medicine are the most potent source so far as transmission of tubercle bacilli to young adults is concerned. So far as we know, there is no other group of young adults so consistently contaminated in such large numbers as students of nursing and medicine." This conclusion is based on years of study and observation and is amply and conclusively supported by facts, presented in a concise and masterly fashion.

Hospital administrators would do well to place this book on their "must" reading list and not to postpone its reading, no matter how busy they are. Particularly, would they do well to give careful attention to the chapter on the "First Infection Type of Tuberculosis Among Young Adults." In this the author deals succinctly with the important problem of tuberculosis among students of nursing and medicine. Hospital administrators should heed the warning "that a large number of girls and boys enter our schools of nursing and medicine and are contaminated with tubercle bacilli for the first time in life, so as to develop a first infection type of tuberculosis. In some schools, approximately 20 or 30 per cent of the students enter with positive tuberculin reactions, but from 88 to 100 per cent are positive on graduation." Learning of such facts, can administrators remain unconcerned in regard to their own hospital and training school?



The protection of nurses, medical students and interns serves a two-fold purpose. First, it protects these young people who by the very nature of their occupation are exposed to the hazards of infection; second, it presents a practical educational course that equips them as militant soldiers in combating disease and healing the sick.

While most hospitals are loath to admit a diagnosed case of pulmonary tuberculosis, few have an established program for the discovery of the unrecognized cases among their patients who are admitted and treated under the erroneous diagnoses of bronchitis, pneumonia and other acute respiratory diseases. So it happens that the case histories of all our tuberculosis sanatoriums abound with the tragic tales of patients who for years wandered from one physician and

hospital to another vainly seeking relief from an ailment which, when proper diagnostic methods were applied, was found to be tuberculosis. The tragedy of these cases lies in the fact that when the diagnosis is finally made, after years of effort and expense on the part of the patient, the disease, as a rule, is far advanced and hopeless.

Since 1904 when the National Tuberculosis Association was organized an ever increasing amount of money has been spent annually on the anti-tuberculosis education of the public. Should the public avail itself of present day medical knowledge, tuberculosis could be relegated among the diseases of minor importance and not take its exorbitant toll from year to year. It would seem, however, that as yet this education has not reached hospitals in a satisfactory manner.

Spread Tuberculosis?

M. POLLAK, M.D.



Otherwise, how could Doctor Myers state that "a good many cases of tuberculosis in infants have been traced to nurses in our hospitals who have unsuspected pulmonary tuberculosis"?

It is a sad commentary on present day practice that only a few hospitals have recognized their opportunities and duties in the fight against tuberculosis while a goodly number of the victims of this disease annually pass unrecognized through their gates although all these institutions are equipped with the armamentarium needed for the discovery of the disease.

The detection of the communicable cases, so dangerous to the hospital personnel and to the community, is a simple procedure. It requires only properly conducted sputum examinations. If it were a routine procedure

in all hospitals to examine conscientiously the sputum of all the patients who expectorate, a fair number of tuberculous patients could be detected from year to year in every institution. It is true that many of these examinations would give negative results, but is this not true of all laboratory examinations? Why is it that we have established the routine of urine examinations, blood counts and the Wassermann test, when these examinations, too, will give positive results only in few instances? Does not the value of laboratory examinations rest chiefly upon the fact that they may lead to a clinically unsuspected diagnosis? Why take exception to sputum examinations? There is not even the excuse that such procedure would be expensive. The microscope is standard equipment in every hospital and

the cost of the stains needed is negligible.

Hospitals could and should go even further. They should establish a routine search for unsuspected cases of pulmonary tuberculosis and other chest conditions by routine x-ray examinations of their patients. F. J. Hodges of the University Hospital, Ann Arbor, Mich., has made the following discoveries:

1. "Routine chest survey may be expected to disclose alarming chest changes in approximately 8 per cent of the patients presenting themselves to a general hospital or clinic."

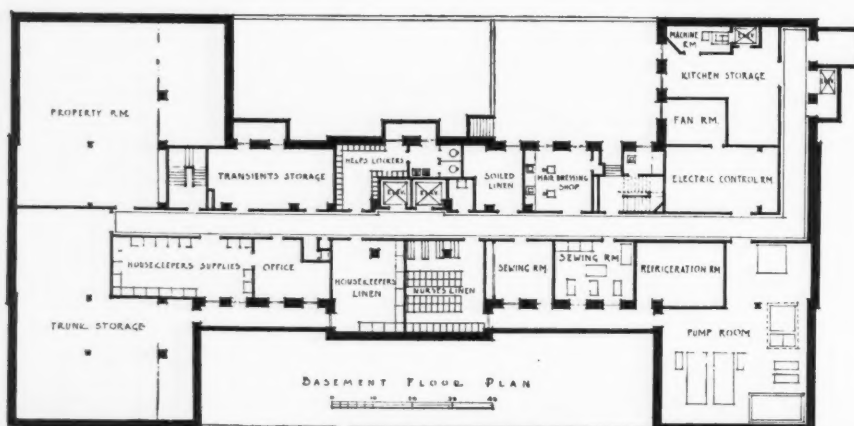
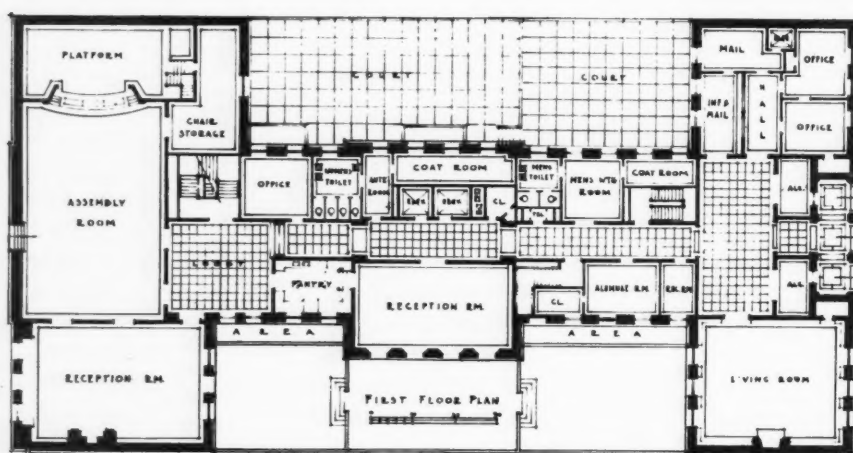
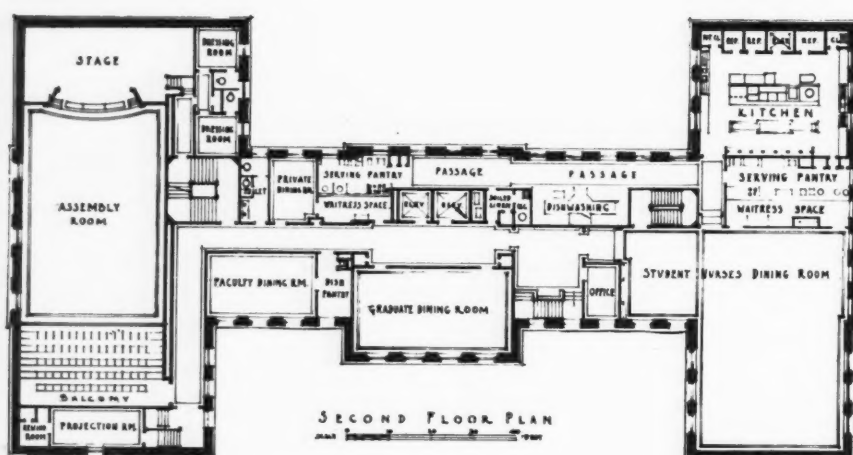
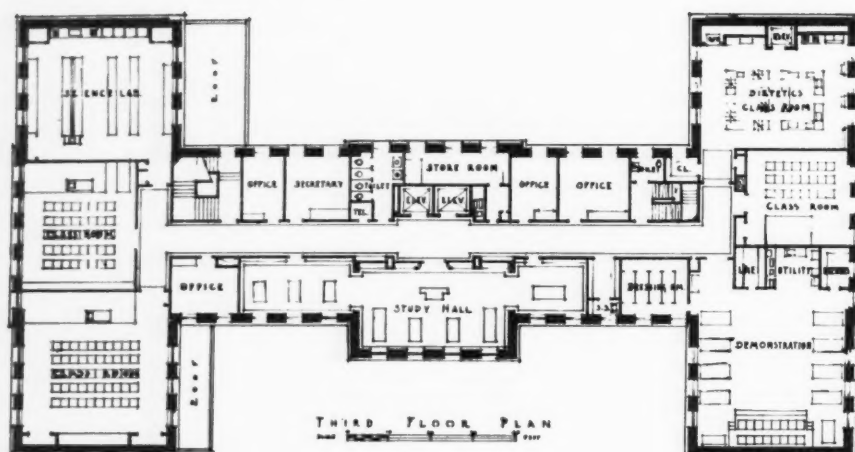
2. "Significant chest disease, unrecognized by other methods and often totally unexpected on the basis of the chief complaint and history, may be expected in more than 1 per cent of large diversified patient groups."

3. "The cost of offering this one type of roentgenographic service to all patients need not constitute an unwarranted financial burden upon patients."

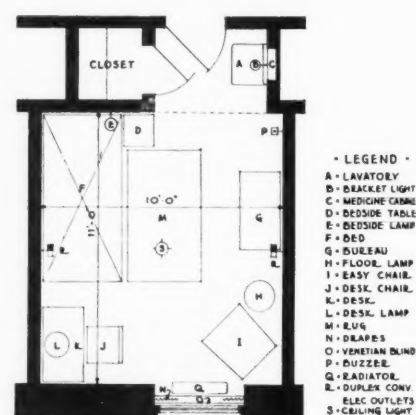
E. A. Pohle, L. D. Paul and W. H. Oatway, who conducted a similar study at the Wisconsin General Hospital, Madison, Wis., came to a similar conclusion; they asserted that: "an evaluation of the procedure showed that 13.3 per cent of all cases studied by routine x-ray examination had significant lesions undetected clinically; eliminating all cases of debatable importance, e.g. configuration of the heart silhouette and enlargement of the thymus, this still leaves 2.9 per cent of significant lesions without clinical symptoms or signs."

Patients who leave a hospital with their disease unrecognized do not reflect credit upon either the institution or the attending physicians. It is to the interest of hospitals and doctors alike, therefore, that simple routine procedures be established by which the health and welfare of their patients and personnel can be protected.

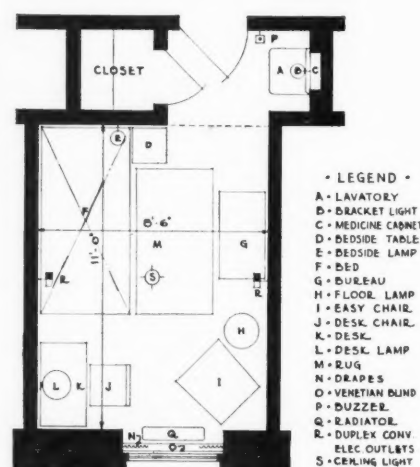
Doctor Pollak is medical director of the Peoria Municipal Tuberculosis Sanitarium, Peoria, Ill.



York and Sawyer are the architects for this residence with individual rooms for 300 graduate and student nurses, an infirmary, suites for department heads, auditorium and recreation rooms, and classrooms, laboratories of several kinds and rooms for study.



Above: Typical layout of bedroom for the graduate nurse. Each room is so arranged that both natural and artificial light fall properly for their various uses. The rooms for graduates are slightly larger than the bedrooms provided for the pupil nurses.



Above: Typical layout of bedroom for the student nurse. Eight color schemes are used for these rooms, each employing simple print curtains, bedspreads, bureau covers and rugs. A small laundry and kitchenette on each floor are for the personal use of students.

All for St. Luke's Nurses

PHILIP SAWYER

UNTIL recently, nursing was regarded as something to be learned by practice rather than by submission to a course of training. But as requirements grew and surgery and medicine became more complicated and exigent in their demands, the natural gift of women did not suffice and it became necessary to train the best material available. Gradually, it was found that an important factor in attracting desirable women to the nursing profession was to make provision for their health and comfort in order to mitigate homesickness, arouse group loyalty and give the newest student nurse the sense of belonging to an important and dignified continuing body.

While not the controlling factor, an adequate physical plant attracts the best nursing material, tends to foster health and contentment and lessens the strain of training. At best, the development of the requirements for living, teaching and exercise results in the building of a first-rate women's club and school, a desirable residence for refined and ambitious women doing group work as professional in its way as the doctor's.

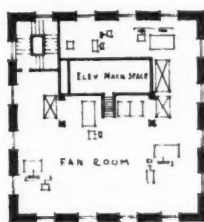
This is what St. Luke's Hospital of New York has built, devoting to it an area 100 feet in width, extending 200 feet north and south from One Hundred and Fourteenth Street, opposite the north front of the hospital, through the block to One Hundred and Fifteenth Street. The buildings between this site and Amsterdam Avenue are owned by the hospital so that they present neatly kept and painted backs to the nurses' west windows.

The body of the plan, a long "I" running north and south and only 40 feet wide, is 11 stories high with a central tower of 14 stories; the ends, extending the width of the lot in each street, step back at the ninth floor and are 10 stories high. The re-

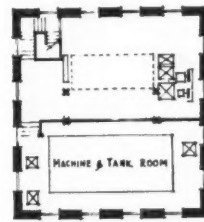
sultant structure is well lighted throughout and is pleasing in mass.

The requirements of the building were: (1) bedrooms for 300 nurses and pupils; (2) an infirmary; (3) suites for the superintendent of nurses and for the department heads; (4) provision for teaching: class-rooms, laboratory, diet kitchen and

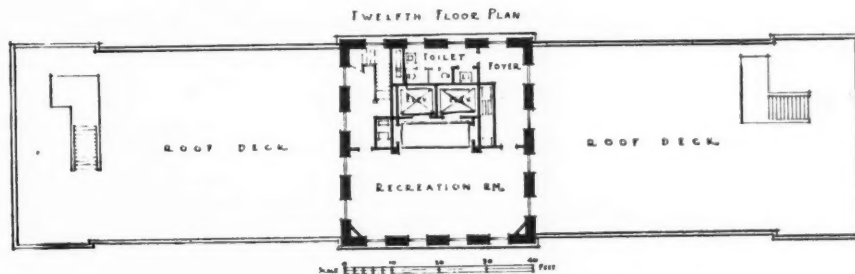
study rooms; (5) administrative offices; (6) dining rooms and kitchen; (7) auditorium, recreation room and gymnasium, open roofs, sun room, game room, library, conversation rooms and a sitting room big enough for group meetings and teas. The last named room, which is next to the auditorium, acts also as a reception room for graduating exercises or for large public functions.



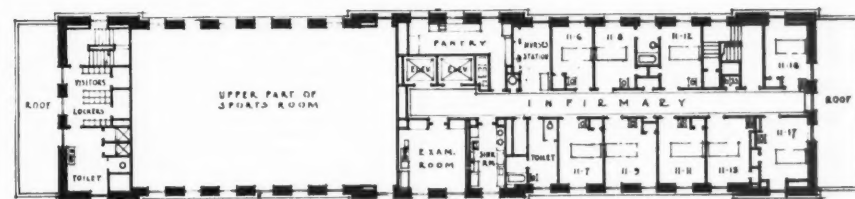
FAN ROOM PLAN



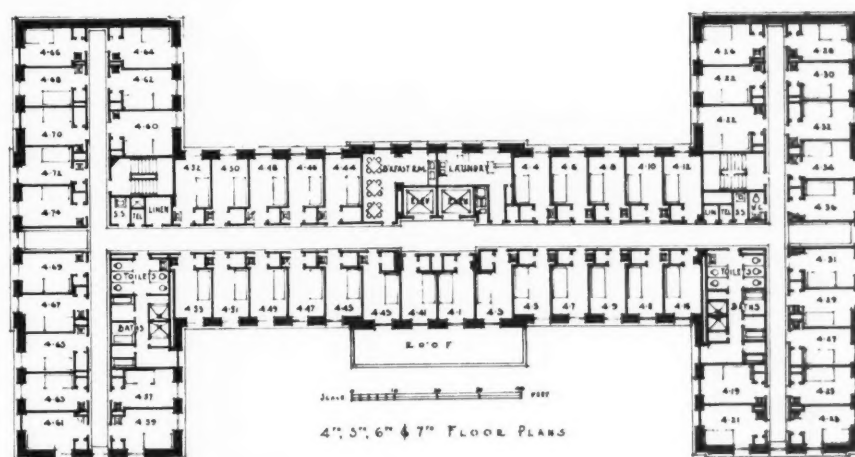
ELEV. MACHINE & TANK RM. PLAN



TWELFTH FLOOR PLAN



ELEVENTH FLOOR PLAN



4", 5", 6" & 7" FLOOR PLANS

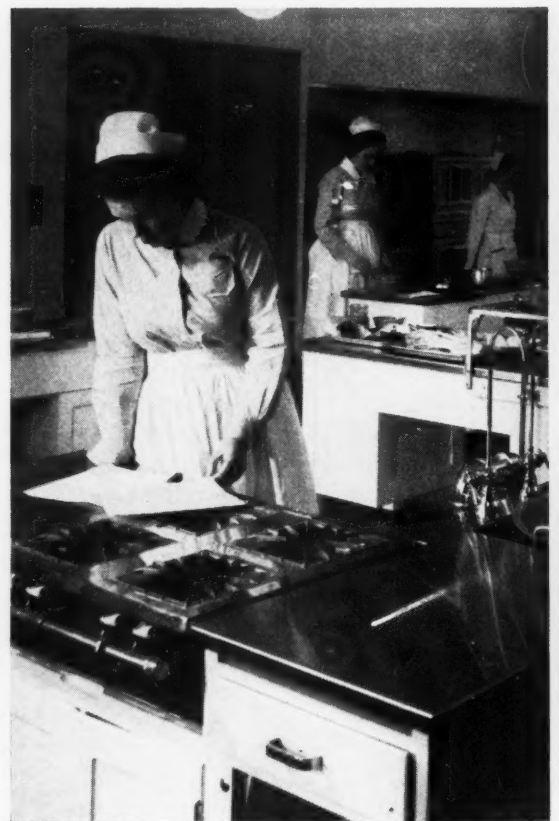
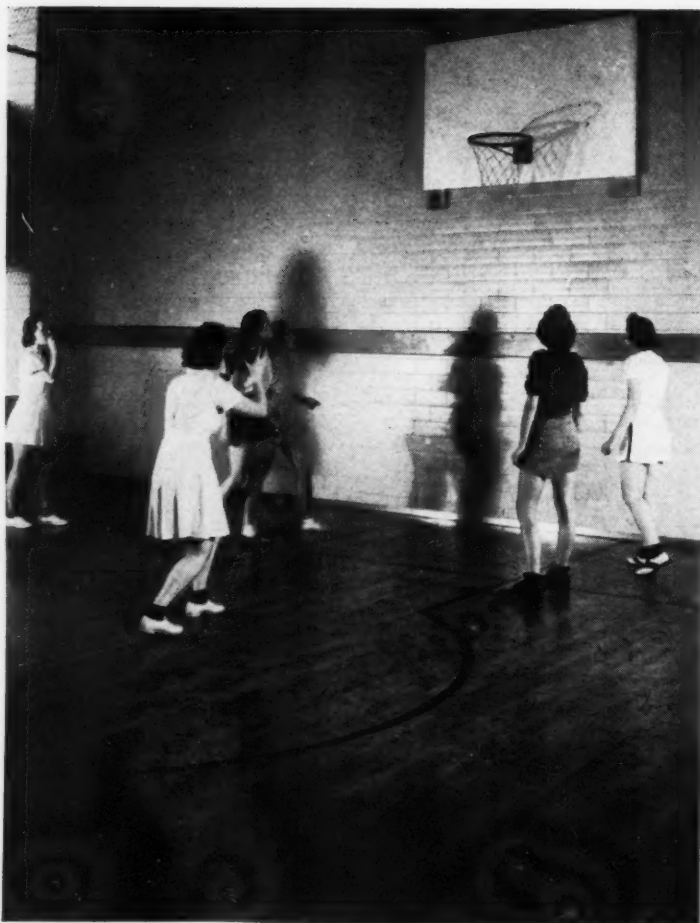
Mr. Sawyer is an architect of the firm of York and Sawyer, New York.



Scenes at St. Luke's



Left: Exterior of 11 story building with 14 story tower. Left, below: Scene in the sports room occupying a portion of the 10th and 11th floors. Above: Dinette for nurses' own use, the popular feature of each floor.

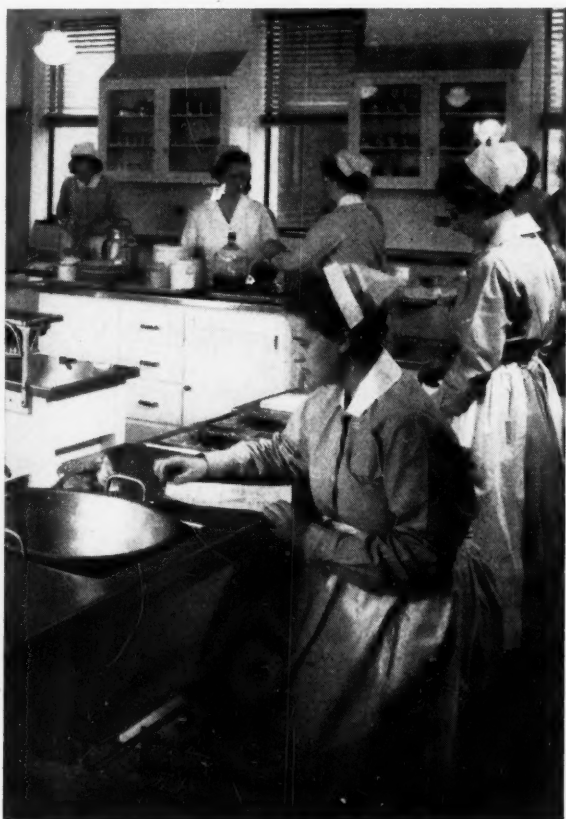


The dietetics laboratory is an example of

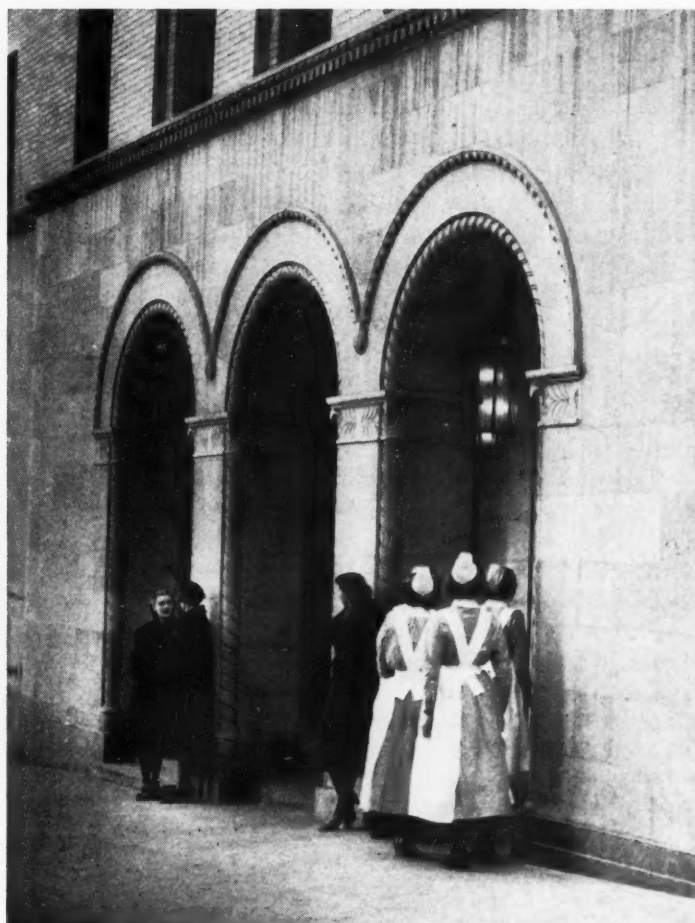
New Nurses' Home



Right: The student nurses' living room has knotty pine paneling, Chinese vermilion doors and silver wallpaper with red Chinese figures. Right, below: Entrance on One Hundred Fourteenth Street. Above: Scene in corridor.



the well-equipped and handsome classrooms.



This sitting room is primarily for the use of student nurses, there being a separate room for the graduates. Rooms are also provided for the use of the alumnae association, a popular feature of the school, and for a museum, in which there are pictures and mementos of the founders of the hospital and nursing school.

In connection with the auditorium, there are dressing rooms and other facilities for theatricals, a projection booth equipped for sound movies and a pantry for the serving of refreshments.

Color was carefully studied while the work was in progress, some thousand designs and stuffs being considered for carpets, rugs, hangings, furniture covers and bedspreads, as well as for the wallpapers in a few public rooms. The finish of each room was set up beforehand with its furniture which was designed for its specific purpose in the required quantities without involving extra cost. Thus the first floor sitting room, off the auditorium, has trim and paneling of knotty pine wood in a natural waxed and rubbed finish; Chinese vermilion doors of composition material, and a wallpaper of silver with a tracery of red Chinese figures. The sofas flanking the fireplace are upholstered in blue material with an interwoven pattern recalling the Chinese vermilion of the doors, and the heavy chairs are done in wine colored fabric with a herring bone weave. The lighter chairs have Chinese latticed backs and the seats are covered with a material of golds and browns and silvers in interrupted circles like overlapping coins.

The bedrooms, all single, are planned to provide a closet, wash basin, bed, bureau, desk, arm chair and a side chair, so arranged that both natural and artificial light fall properly for their various uses. There are eight color schemes for these rooms, each using simple print curtains, bedspreads, bureau covers and rugs, so that a choice is offered the occupants. Rooms are of two sizes, the larger for graduate nurses. On each floor are a small kitchenette with two tables, each seating four, where the girls may prepare light in-between meals and a small laundry with tubs, irons and steam dryer for personal use.

The exterior of the building is of a light gray-tan brick. Entrance doors and lower window grilles are of stainless metal and the entrance loggia on One Hundred and Fourteenth Street is flanked by panels of marble in either end and has a vaulted ceiling of cerulean blue glazed tile.

The building has now been in use long enough for the hospital administration to have tested it thoroughly and, since the experience of those who occupy a building is so much more valuable than the intentions of the architects who plan it, it is significant to note the comments of Helene Olandt, director of nurses:

"Several administrators have said that an outstanding feature of the building is the lighting of the bedrooms, the outlets and lamps being so arranged as to provide light for every purpose. Nurses are encouraged to teach sight conservation but are rarely provided with proper light to conserve their own sight.

"Many nurses, particularly those who are following administrative courses in Teachers College, comment on the fact that the whole building has been planned with re-

gard not only for actual living but for maintenance and upkeep. This is shown by the distribution of hoppers, bathrooms and toilets, convenient for the maids as well as for the nurses. Everyone is impressed with the good taste of the building and furnishings.

"The features that give comfort and joy to the nurses are the solarium, which is light, airy, comfortable, homelike and conducive to relaxation; the spacious roofs; the kitchenettes on each floor, which are used for late breakfasts and as an evening gathering place, and the gymnasium and playroom.

"The separate rooms for nurses in the infirmary are much appreciated. The telephone system on each floor is convenient. The classrooms are well arranged, lighted and ventilated and the building has an unusually homelike atmosphere for an institution."

The building is constructed with a thoroughness and care that should give it a long life with low maintenance and it is hoped that many classes of St. Luke's nurses will look back on the time spent in it as a profitable and happy time of life.

Control of Cross Infections

A TRIPLE card system for checking cross infections is in use at the University of Chicago Clinics. These hospitals control the spread of infectious diseases by classifying every patient according to the likelihood of any infectious development and by instituting precautionary measures according to these classifications.

Under this system, all quarantinable cases, such as smallpox, measles and whooping cough, are identified by a red card on the door of the hospital room. Strict quarantine is enforced, no visitors are permitted and the patient may be removed from his room only on the written order of the medical officer.

A yellow card is displayed on the door of a room occupied by a patient with typhoid fever, dysentery, venereal disease and similarly infectious disorders. Under the yellow card

regulations visitors are permitted after receiving instructions from the nurse governing the nature of their contact with the patient.

Patients with pneumonia, influenza, pulmonary tuberculosis and upper respiratory infections are designated by a blue card; instructions include masks and gowns for all attendants and visitors, transfer of the patient only by the intern's order and sterilization of all linens, utensils, trays and dishes immediately after use.

Closer regulations of visiting hours and strict enforcement of these rules with the entire medical and nursing staff will drastically reduce the incidence of secondary infections in all hospitals, according to Dr. Clement C. Clay, former medical assistant to the director of the university clinics, now of St. Barnabas, Minneapolis.

How Small Hospitals Fit Into a **State-Wide Insurance Plan**

E. A. van STEENWYK

THE responsibility for making hospital care insurance available to all communities in the state seems to rest largely upon the hospitals. The problems of organization for a large area combining many communities are not the same as the problems for a single community. For that reason, in making the plan available throughout the state, the hospitals both in the communities already served and in the rural districts not yet served must be prepared to give and take. Certain reasonable conclusions must be arrived at with full cooperation of all concerned.

Two Views on Fixing Rates

One of the important matters to be considered is the question of rates to be paid to participating hospitals in smaller communities. There are two points of view currently expressed in group hospitalization with respect to this problem. The first, and perhaps the more widely adopted, is that all hospitals, wherever they may be situated and whatever their cost of operation may be, should be paid the same per diem rate.

The justification for this point of view is that all hospitals are doing the best job they can. The fact that a hospital happens to be in a smaller community does not mean that it is not doing as good a job as a hospital situated in a larger community. Therefore, all hospitals should be paid the same amount. For certain organizations in which the metropolitan area extends into rural areas, with the same hospital costs in the rural area, this is a valid viewpoint.

The other and, I think, more realistic point of view, is the one adopted by the board of trustees of the Minnesota Hospital Service Association. Good work is done by large hospitals and small hospitals, in large cities and in small cities. While a hospital

care plan should be interested in the quality of the service rendered to subscribers, it is not primarily an agency for the analysis of such service.

Therefore, no plan ought to assume the position of patron to smaller hospitals. The basis used in determining the rates paid to all hospitals is to be found as a result of consideration and study of the maximum payment made on a per diem basis in the metropolitan areas; the per diem income for the previous year for the particular community hospital, and the total cost of operation on a per diem basis for such hospitals the previous year. Consideration and study of these three factors will undoubtedly result in a fair per diem payment to the hospital.

This method will provide just basis not only for reimbursing hospitals for care rendered but also for meeting the high costs of initial promotion in smaller communities. There can be no question but that the smaller the community, the higher the proportionate expense for all initial enrollment procedures.

Representation on Board

The second consideration that should concern hospitals in a state-wide plan is the method of representation of all hospitals in accordance with the degree of their responsibility and the population served (in the area) on the governing board of the agency that makes the service available. No one would deny the right of a hospital or an individual community to representation on such a governing board. Yet the degree of responsibility of a smaller hospital in a smaller community is quite different from that of a larger hospital in a larger community. If the hospital and the citizens of a community both agree to accept the responsibilities

ties that membership in a hospital care plan implies, both the citizens and the hospitals should in some way be represented on the governing board of the agency.

The position of metropolitan hospitals, the leadership they have exercised and the responsibilities they have assumed should be recognized. Yet it should also be recognized that economically rural hospital interests are not the same as metropolitan hospital interests and provision should be made for a fair basis of representation. If representation for the smaller hospitals has been provided for on the governing board of the hospital service plan, inequities that may develop in the experience with any hospital or group of hospitals may be adjusted from time to time.

No Magic in It

This is not a serious problem if all hospitals come early to the basic conclusion that no miracles are going to be worked by the group hospitalization plan for the smaller communities throughout the state. There is no magic about group hospitalization. As an economic device it can do no more than the dollars and cents that the particular plan collects make possible. A realistic approach on the part of administrators and trustees of smaller hospitals to the problems of both the hospital per diem schedule and the matter of representation is essential for any effective consideration of a state-wide plan.

A third consideration, which will require the agreement of hospitals in both the smaller and larger communities, is the matter of reciprocity between hospitals within the state, *i.e.* whether or not the subscribers have a right to use all of the hospitals participating in the plan. No single consideration in Minnesota has had as much emphasis as this. Yet,

Mr. van Steenwyk is executive of the Minnesota Hospital Service Association, St. Paul.

in the New York and North Carolina plans where service is available in all hospitals regardless of where the subscriber lives the incidence of hospitalization of out-of-town patients for all hospitals has remained about the same. The truth of the matter, it seems to me, is that patients want to be under the care of their own physicians and would like to be hospitalized in their own community hospital near their families and friends.

If the gains that central organization makes possible are to be fully utilized it becomes increasingly obvious that all communities must operate on nearly the same basis; that all subscribers must, in the eyes of the central set-up be the same. Variations in the type of accommodations that various subscribers may use, variations in the extent of coverage because of certain disease limitations for certain subscribers and variations in the availability of hospitals must be limited to a minimum if full utilization of the central set-up is to be made.

A group plan succeeds in proportion to the extent that simplicity is emphasized in all administrative details. There seems to be no good reason why the subscribers in any community within a given area should not have the benefits of the plan in all hospitals within that area, in addition to a flat per diem payment on their behalf when hospitalized in any nonmember hospital.

Another matter to be considered by all hospitals is the way in which an effective public relations program leading to group hospitalization coverage in each area can be brought about. The public relations job in group hospitalization must be undertaken from the points of view of four groups: (1) prospective subscribers, (2) employers, (3) hospitals and (4) physicians. The job of acquainting prospective subscribers with the desirability of the service offered is properly the concern of the employed staff of such plans. Reaching employers should also be the staff's responsibility. However, the importance of the hospital administrator in selling the plan to every member of his board of trustees and every medical staff member of such a board cannot be overemphasized.

Commercial insurance companies selling low rate hospital insurance policies are now trying in every way to capitalize on the public demand created for group hospitalization by nonprofit plans. Campaigns undertaken by certain insurance agencies imply the hope to policyholders that under a commercial insurance policy a policyholder may use free ward facilities and either pocket the difference or pay this to the physician. These campaigns emphasize surgical schedules that commercial plans are now offering, even though the schedules are obviously inadequate, are hedged about with qualifications and are considerably above the rate that most employed groups can pay. The twin facts that free service in a ward is available only to indigents who have qualified as such and that all policyholders must obtain "proof of loss" from the hospital before being reimbursed are not considered in making such implications. It is not until a policyholder attempts to cash in on his policy that the truth becomes known.

Inasmuch as the interests of hospital administrators, physicians, employers and subscribers in every community are the same, it is to everyone's advantage to support the nonprofit plan that represents them all.

Four Minnesota Conclusions

As a result of our experience in Minnesota, certain conclusions are inescapable. They have a bearing in determining whether the bother that this additional work entails is worth while.

The first conclusion is that the unit to be considered in enrollment is the family, not the individual. Few insurance company plans, for good reasons, make this possible on a basis that people of moderate income can pay or upon a basis that permits any significant portion of the population to participate. There just isn't enough money left after paying the hospital bills to repay capital adequately for the risk assumed. Community hospitals, on the other hand, assume the risk anyway so that nothing more than increased utilization of facilities is at stake. While it is true that such increased utilization must cost money, the differential favors hos-

pitals and the broad purposes of their public health program.

Second, a hospital service plan is a service agency and not a financial institution. If, in the future, the structure of the hospital service association rates and benefits needs adjustment because benefits are either too great or not great enough, adjustment can be made on a cost basis. Such a plan will not be discredited in the eyes of the public if complete frankness with regard to the business has been maintained. The only period that hospitals need greatly to be concerned about is the period of one year following the date of contracts. For such a short time, most emergencies can be taken care of with a relatively small reserve, such as Minnesota and most other nonprofit plans now have.

Third, a hospital service plan increases the utilization of voluntary hospital facilities and gradually a permanent increase in demand makes itself felt. Already in Minnesota one out of seven members of the plan is hospitalized each year but for fewer days than the general average of similar cases. Commercial insurance companies cannot use as much of their funds to pay for hospital care as nonprofit plans. If group hospitalization is recognized for what it is, simply an extension of the voluntary hospital system, the importance of this conclusion to a higher level of public health is apparent.

The fourth conclusion is that, in order to do an effective job, the work must be carried on as is hospital work itself, on a nonprofit basis. There just is not room for profit in hospital work. This has been demonstrated time after time. The same truth holds for this economic extension of the hospital system.

Hospitals and professional groups are under these plans offering hospital service in a new way. The service offered must be complete. The organization must operate efficiently and at a cost of not more than from 10 to 15 per cent. However, any analysis of such plans as they have developed in America must conclude that this new way can become effective for any entire community only if everyone and every health agency in community or state works for the success of a single agency.

With Benefit of Clergy

RUSSELL L. DICKS

THE clergyman's first concern in the sickroom is to do no harm. Working within this caution he may be of significant help in the patient's recovery, if peace of mind and renewed confidence can be said to contribute to the recovery of health, and most medical men hold that they do. If the patient is not to recover the clergyman may be of help in aiding the patient and his family through the trying experience of death.

Granted that the minister is alert to the possibility of doing harm in the sickroom and is careful to avoid it, the questions of interest to physician and patient are: How does the minister go about his work in the sickroom? What is his attitude? Is he different from other professional workers, *i.e.* the physician, the nurse, the medical social worker? Is he only a visitor or more than a visitor?

Clergyman's Purpose

The clergyman's interest and purpose in the sickroom may be stated in the simplest form as being a desire to aid in the recovery of health in any way possible and to aid in the spiritual growth of the sufferer.

Pain, fear, bitterness, guilt, worry and loneliness, all of which are frequent visitors in illness, have their effect upon the religious outlook of the ill as well as upon recovery. Many patients have setbacks when the only cause that can be discovered is annoyance at a caller, bad news, a book they have been reading or some similar external stimulus.

On the other hand, dramatic leaps forward in recovery are often made through the efforts of those in attendance.

A patient who had been nauseated for several days for no apparent reason was called to our attention. One of the ministers working in the hospital went to see her. With a little effort on the minister's part her story

of bitterness toward those around her came out along with the repeated statement that she thought she was dying. For three weeks she had been on a diet of which she wholeheartedly disapproved. Because of her disapproval of the diet, she had taken a dislike to the physicians and had come to disbelieve everything they told her. Furthermore she disliked her nurse. Her family, thinking that she was getting along satisfactorily, had neglected to come to see her frequently.

As day after day the doctors passed by her bed on their rounds her brooding and bitterness increased until she had decided that everybody had deserted her and that she was being left to die. The minister passed the essence of the story on to the physicians who began to give the patient more attention and, as one of them said, "to treat her more like a human being." Within three days she was eating normally and within a week she was home and well on her way to recovery.

Five and a half years ago, upon graduation from a theological seminary, I went to the Massachusetts General Hospital in Boston to work as a minister, expecting to stay three months. Frankly, I went out of curiosity. I believed that religion had a function to perform in the face of stress and I wanted, if possible, to discover what that function was and to learn why religion aids one person and not another.

Still Seeks the Answer

After five years of intensive work, during which time I have seen hundreds of persons of various backgrounds suffering every form and degree of stress, I am still looking for the answer.

There are many answers and yet there is none since, actually, one does not observe one person against another but rather each against himself and his own potentiality. What is heroism for one is cowardice for an-

other; what is a testing of character for one is as nothing for another. Work with the sick is highly individualistic, slow and time consuming. Every person tests the wit, intelligence and imagination of the minister, and here lies one of the first principles that forced itself upon my attention in work with the sick.

Each patient must be accepted as he is at that time and each succeeding time when he is seen. His past experience, his limitations, his prejudices, his ideas, his humor, his imagination, his hopes, his affections and loyalties, and not those of the minister, must be accepted and utilized; nothing can make it otherwise. The minister's task in working with the sick is not to induce the other person to believe as he does, although that may be a result; it is to aid the sufferer to move forward according to the patterns of his own life.

Patient Is Center of Picture

The result of such an approach is that the patient is the center of the picture and not the clergyman. The patient and his soul's outreach, his stress or his ease are the focus of attention. The minister's own condition, problems and interests are secondary. In actual experience there are many exceptions to this rule. There are times when the patient turns attention upon the minister because he prefers not to talk about himself and his own condition or because by temperament and practice he is accustomed to give attention to others.

During the past several weeks I have been calling upon such a person. She has suffered and is suffering enough to rock the saints. Her friends gather around her to "encourage her," they say, but actually it is to receive encouragement. Throughout a busy lifetime she has been an outgoing person, listening to and expressing enthusiasm over the interests of others; now as she comes up to the final days of her life it is the same. Such persons are rare, especially in their own sickroom.

The author is chaplain of the Presbyterian Hospital, Chicago.

Illness forces attention, their own and others', upon themselves, through pain, through the efforts of others in the care of them and through the changed conditions of being ill.

The sick have taught me to minister to the sick. During my early days in this work I listened to all kinds of stories, fearful lest I be called upon to give the answer to some of the things I saw and heard. I was anxious to learn what was in the minds of the patients as they passed through various degrees of stress. They told me eagerly and then, much to my surprise, thanked me for having come to see them, saying that they were helped; and they seemed to be.

After five years the questions concerning the clergyman's place in the sickroom can be answered. He is not a visitor. He is a professional worker disciplined and trained with

specific methods at his command and accumulated experience behind him. He may visit with a patient just as the physician may visit, but his eyes are always focused upon the patient's greater need and he is trained to recognize signs of restlessness, apprehension and worry. His method reaches its dramatic climax when, through prayer adapted to each patient's need, he directs the sufferer's attention to specific objects and ideas, thereby turning restlessness into definite channels.

The charge is sometimes made that the clergyman carries the needs of his parishioners upon his heart. Certainly; and so does the conscientious physician. That burden does not limit his effectiveness because experience has disciplined him and his method guides him just as does that of the physician, while his faith and his task constantly renew him.

nicians and interested physicians.

11. To check all equipment and supplies for the department. An accurate tabulation of all costs relative to material, repairs, help and supplies should be obtained at regular intervals from the central office of administration. This is necessary to put the department on a paying basis.

The intern on laboratory service should see new cases referred to this department when the director is not present and should become familiar with all types of treatment given in the department.

Treatment should be administered by trained physical therapy technicians who are graduates of a recognized school for physical therapy and are registered with the American Registry for Physical Therapy Technicians. The technician in charge should have had preliminary training as a nurse. All technicians should be members of the American Physiotherapy Association. Naturally they receive good salaries. In Chicago a technician in charge of a department receives a minimum of \$165 a month, plus meals and laundry.

The duties of the physical therapy technicians are:

1. To see that all machines and equipment are given the best of care.

2. To see that the proper technic is followed as ordered by the doctor in charge of physical therapy.

3. To sign all requisitions for equipment and supplies, but, where amounts are large, to obtain the approval of the doctor in charge.

4. To report any defects in machines or equipment immediately.

5. To see that all new patients are seen by the medical director of the department and that he prescribes for them.

6. To see that all patients are checked up weekly by the director.

7. To note carefully any patient who can be discharged earlier than the allotted time and to bring him to the attention of the doctor in charge of physical therapy.

8. To consult the doctor in charge of physical therapy should any question arise as to the type of treatment or technic.

9. To make records and progress notes on all patients.

Rules for Physical Therapy

JOHN S. COULTER, M.D., and W. H. NORTHWAY, M.D.

THE first thought in establishing a physical therapy department in a medium sized general hospital must be on proper personnel. Many departments with good equipment and poorly trained personnel have failed in their functions but we have never known one with good personnel, with or without elaborate equipment, that did not grow and expand.

The part-time services of a medical director are necessary. Arrangements may be made with a physician who is supervising one or more hospital physical therapy departments. The director needs some special training. Several medical schools offer short postgraduate courses.

The duties of the physician in charge may be summarized as follows:

1. To see all new cases and to prescribe for the patients in consultation with the physician referring the case.

Doctor Coulter of the Northwestern University faculty is in charge of physical therapy at Passavant, St. Luke's and Illinois Central hospitals, Chicago. Doctor Northway is director of the department at Stanford University.

2. To see all cases at least once every two weeks and to decide whether maximum improvement has been reached or whether treatment needs to be changed.

3. To see cases at any time at the request of the technicians.

4. To call the attention of the staff from time to time to certain types of physical therapy that may be helpful.

5. To prepare and maintain a bibliography of physical therapy.

6. To check with the chief technician to see that all directions are carefully carried out.

7. To make the department as truly scientific as possible and of real assistance to the members of the staff.

8. To stimulate research among younger staff members.

9. To interest the physicians of the hospital in physical therapy, showing them the work being done in the fields in which they are interested.

10. To organize a teaching program for the nurses, interns, tech-

Patient v. Operating Table

BENJAMIN RICE SHORE, M.D.

THE correct position of a patient on the operating table is arranged with two problems in mind: (1) the protection of the patient from bodily injury and (2) the facilitation of the work of the surgeon. In most instances these two factors can be easily correlated into a simple and well-organized routine. Only under definite and well-indicated conditions should either of these factors be altered at the expense of the other.

The ordinary operating table is of metal construction and is usually covered with some sort of a rubber or composition pad. The hardness of such a table is capable of producing harm, especially in the case of prolonged operations on unusually heavy individuals. The commonest injury is to the back and is due to the lack of support given the spine in completely anesthetized and relaxed patients.

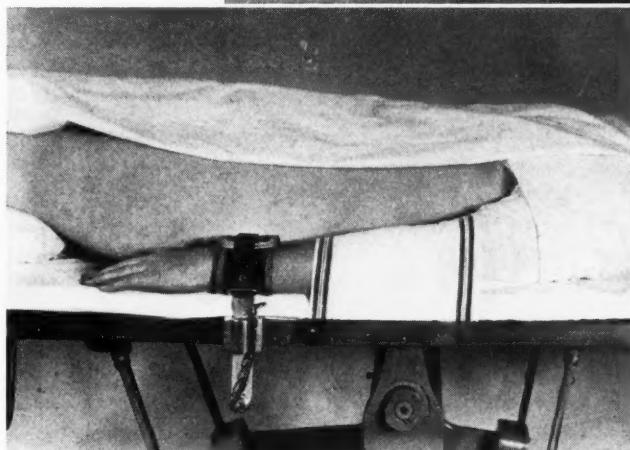
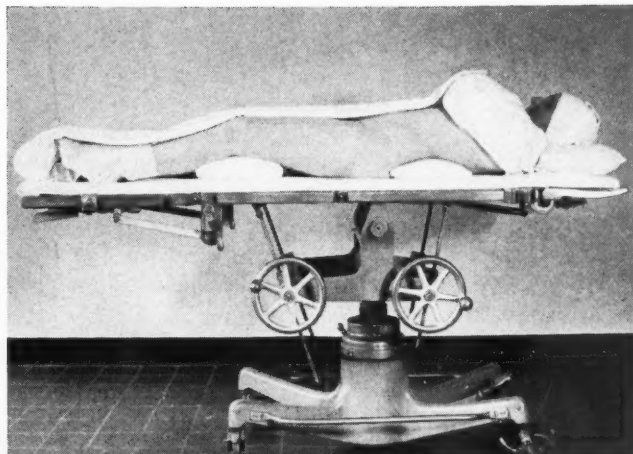
Postoperative backache can be prevented to a large degree if the lumbo-sacral region and knees are supported on pillows or special pads that are not so hard as to cause undue pressure and are not too soft to give real support. Horsehair is an ideal material for these pillows. They should be rectangular in shape and the one for the knees should be about twice the thickness of the one for the back. Sand bags are totally unsuitable.

The possibility of irritation from unusually rough or ragged canvas drawsheets or from the chemicals that are used in preparing the field of operation and are allowed to gravitate beneath the patient should not be forgotten. While these injuries may seem trivial, they may cause extreme discomfort and mean much in the convalescence of the patient.

With a patient in the usual dorsal position, the method of restraint of

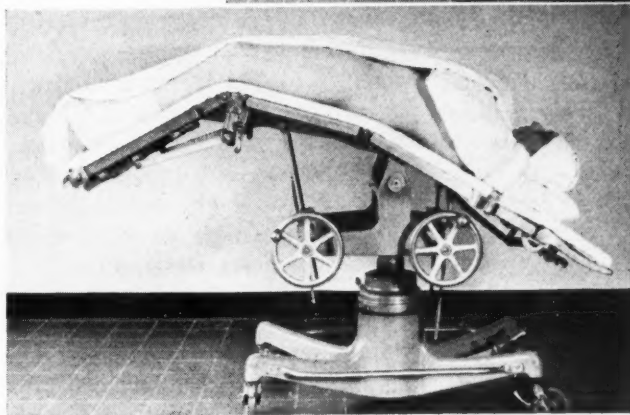
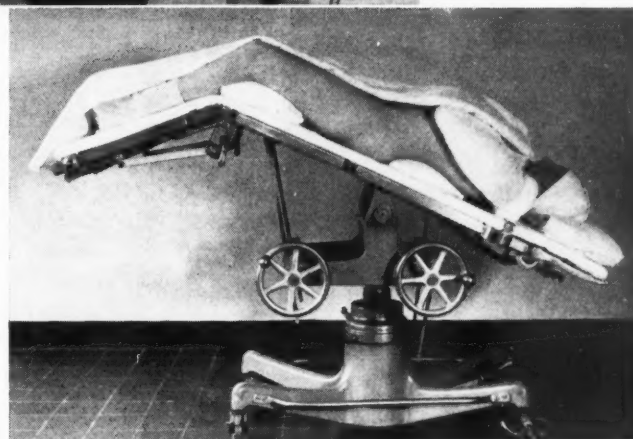
Doctor Shore is attending surgeon at St. Luke's Hospital, New York.

Right: Normal dorsal position showing lumbo-sacral region and knees supported on pillows, preferably of horsehair.



Left: Arm restraint by use of padded leather wristlets and a loose drawsheet around the elbow region to prevent the arm from sliding over the edge of the table.

Right: Correct Trendelenburg position showing the patient well relaxed, with back and knees supported on pillows. Note the well-padded braces at the shoulder level.



Left: Patient is being placed in the Trendelenburg position without head being lowered and feet raised simultaneously. Severe backache follows such stretching.

his arms and hands is of more than ordinary importance. It is the practice in some institutions, following the induction of anesthesia, to place the patient's hands palm down on the pad of the operating table and to hold them tightly beneath his thighs by means of the canvas drawsheet. This is not the correct or satisfactory method for routine use.

The most important objection to this practice is the complete impossibility of restraining a patient who is struggling during the early stages of anesthesia or who becomes too lightly anesthetized during the course of an operation, even though his hands have been carefully wrapped in the drawsheet. Aside from this inconvenience, there is possibility of real damage when the hands are placed beneath the thighs of heavy patients for a considerable length of time. In one case which has come to my knowledge, restraint of this type produced a hematoma of the hand with associated loss of function and precipitation of a disabling arthritis of this extremity.

For Special Table Positions

All these objections can be eliminated by the use of well-padded leather wristlets that are attached to the sides of the operating table and are applied after the patient is asleep. The only objections that I have ever heard to the use of wristlets is that they are somewhat cumbersome and difficult to apply and that musculospiral palsy may result if the patient's arms are allowed to slide over the side of the table. The latter is easily prevented if the elbows are loosely wrapped in a drawsheet so as to hold them on the table. In this position complete restraint is possible and injury to the patient is reduced to a minimum.

There are numerous special operating table positions that have been devised to give proper and adequate exposure to the various body cavities and to make the necessary procedures easier for the surgeon to carry out. The Trendelenburg position is one of the commonest of these and when properly used it can be of great benefit to the surgeon. When improperly used, it can be both a hindrance to the surgeon and distinctly harmful to the patient. I am

thinking especially of the stretching that occurs when the patient's head is lowered and the feet are not raised simultaneously. During this maneuver the bend in the table acts as a fulcrum over which the abdominal and thigh muscles are stretched; this is accentuated if the patient's knees have already been flexed to prevent sliding on the table. Not only is the stretched position, if maintained during the operation, harmful to the patient but the tense abdominal muscles may actually hinder the surgeon in his exposure of the operative field in the pelvis.

Poorly Placed Braces Dangerous

Poorly placed or poorly padded shoulder braces for the support of patients in the Trendelenburg position are potentially dangerous and may lead to varying degrees of injury, depending on the weight they support and on the duration of their use. I know of one instance of a prolonged pelvic operation on an obese patient in which poorly padded and poorly placed shoulder pads produced damage of several months' duration to the left brachial plexus, the arm in this case being also markedly abducted during the course of the operation for the purpose of an intravenous infusion. Finally, it must be remembered that the rapid lowering of the head of the table, especially in obese and short-necked patients, may cause respiratory embarrassment and temporary circulatory failure.

Of special interest is the position of the arm in patients on whom radical breast amputations are performed. In many clinics it is routine for the arm on the diseased side to be fastened firmly to an arm board and left there for the duration of the operation, which may be anywhere from two to four hours. It seems to me that most of the severe joint and muscle arm pains of which many of these patients complain after operation can be traced to this rigid position of the arm plus the drying effect of the bright lights on the exposed brachial plexus. During the past several years I have made it a practice to have the arm held by a nurse or an assistant during the course of a radical mastectomy in the position of semiabduction of the

upper arm and right-angle flexion of the forearm. When in this position, the arm is unintentionally moved from time to time by the person holding it and intentionally moved by the surgeon to obtain better exposure of the operative field. Several years' experience with this method of managing the arm during radical mastectomies has convinced me of its usefulness and practical value.

In head and neck operations, especially those in which tracheal aspirations of blood or pus may be possible, it is important to place the patient on the operating table so that the pharynx will be at a lower level than the epiglottis. This is usually the duty of the anesthetist and can easily be relegated to him if he is well trained.

Dr. Mather Cleveland says that he has seen a dislocation of a cervical vertebra as a result of the forceful twisting of the head in a very relaxed patient.

Other special positions of patients, such as those for perineal, kidney, chest, spine and head operations, are likely to be varied according to the individual ideas of the physician.

Footstools for Operating Team

Considering this whole problem of the patient's position solely from the surgeon's standpoint, it is of paramount importance that patients be so placed on the operating table that they can be worked on with a maximum of exposure of the operative field and a minimum of fatigue to the operating staff. Operating tables should be constructed so that they can be raised or lowered to a level that will accommodate surgeons of different heights and patients of different sizes. This is certainly not true of the ordinary table at the present time.

Furthermore, the height of the operating table should not be arranged solely for the convenience of the operating surgeon, with no regard whatsoever for his assistants. Footstools of varying heights can be used so as to accommodate the natural operating position of the shortest of the operating team to that of the tallest and in this way strained posture will be eliminated on the part of the entire team.

Small Community Trends

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Committee on Research in Medical
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FIFTY-NINE of the 93 cities with populations of more than 100,000 have municipal or county hospitals. Since some of these governments operate more than one hospital we find that out of the total of 467 city and county hospitals in the United States, 81 are in these large cities and 386 are in less populous cities and counties. In 152 counties the local governmental hospital is the only general hospital in the county, whereas the remaining 315 city or county hospitals are in places that have a voluntary or proprietary general hospital.

Let us first consider the organization of these city and county general hospitals. In general, these hospitals may be grouped into four broad classes. The first group, constituting nearly a third of the 334 local governmental hospitals that returned the questionnaires, is controlled directly by the tax-levying body, the county board of supervisors or the city council. Supervision of the hospital is merely one among many functions of these bodies. More than half the reporting hospitals, however, fall into the second group, in which control is delegated to a special board of trustees. These are usually appointed by the mayor, the city council or the county supervisors. Outside groups, such as the county medical society, the local chamber of commerce, or, in a few southern hospitals, the ministers of local churches are occasionally authorized to designate members of the board.

In a small group of 21 hospitals, the boards are elected by popular vote. The final group has 43 hospitals which are mostly large, are usually located in large cities and are under appointed officials, who may be directors of health, welfare, public

This article carries on a study of governmental general hospitals presented in the July issue of this magazine. The authors are greatly indebted to L. F. Hallett, supervisor of field service of the American Municipal Association, for preliminary analysis of the questionnaires concerning the organization of hospitals.

safety or the like. They are appointed by and responsible to the mayor or to the city manager. In New York and St. Louis, there is an especially appointed hospital commissioner. Some large city hospitals, as in Boston, have boards of trustees.

Provision of funds for the hospitals is always in the hands of the local governing authorities. If the county board of supervisors or the city council supervises the hospital directly, financial control is, of course, also vested in this body. Especially appointed boards or appointed officials, however, must apply to the locally elected governing authorities for funds with which to operate the hospital. While budgets are frequently presented, appropriations are not always made on a budget basis. Sometimes the operation of the hospital is financed by a special tax levy and sometimes by a fixed annual or biennial grant. In some cases, there is no regular appropriation but the taxing body stands ready to vote a deficiency appropriation or to levy a special tax

A study of the functions and the finances of municipal and county hospitals

for hospital support. In certain instances, the reports from the hospitals declare that the institution was "not allowed to have a deficit" or "was expected to be self-supporting." Indeed, the proportion of hospitals in which patients pay for all or a substantial portion of the operating costs is surprisingly large.

Certain exceptions to the foregoing statement will come to mind. In California, for example, sharp issue has been raised concerning the legal right of county hospitals to receive paying patients. It is apparent from

the present study, however, that this issue has not been raised in most other states.

In fact, among 247 hospitals replying from cities with populations of less than 100,000, 45 per cent, as the following tabulation shows, recorded receipts from patients which equaled three fourths or more of the expenditure; in two thirds of the hospitals, income from paying patients covered 50 per cent or more of the total current expenditures.

Proportion of Expenditures Covered by Receipts From Patients in 247 Hospitals

From Patients	No. Hosp.	Per Cent Hosp.
None or under 1/10	62	25
From 1/10-1/2	22	9
From 1/2-3/4	53	21
3/4 and over	110	45

Where are the 163 city and county hospitals that are more than half supported by receipts from patients? More than three fourths are in cities with less than 16,000 population. Their location is not limited to a particular section of the country. One or more are found in 33 states, although almost three fifths of them are located in eight states: Illinois, Michigan, Indiana, Texas, New York, Kansas, Wisconsin and Minnesota. Not location *per se* but location in respect to general hospitals under voluntary control appears to determine whether or not governmental hospitals receive any considerable income from paying patients. More than two fifths are the only general hospitals in their counties. Nearly two fifths more provide the only general service in the town in which they are situated.

These small city and county hospitals seem to be community hospitals, using tax funds when necessary for the care of needy patients unable to pay for their care but serving all economic groups and depending upon the private patients of the

physicians in the community to provide a large share of the income. Some hospitals even report an income from paying patients in excess of the recorded costs of maintenance. A few report trust funds, given by private philanthropy, which can be drawn upon in case of deficit. Occasionally, while tax funds were paid for the erection of the hospital building, receipts from patients are supposed to cover the costs of operation. A few hospitals, on the other hand, have been built by private funds and then given to the city for operation and maintenance, sometimes with a small endowment fund to help take care of patients without means. In most cases, these hospitals are governed by boards of trustees appointed by the local government and their direct dependence upon the local public officials may be limited to the extent to which they must draw on them for funds.

Some Examples

Some illustrations may be of interest. There is a 145 bed hospital in a Nebraska city of 75,000 of which the superintendent writes as follows: "This hospital is owned by the city but is supported by patients and by endowment and not by tax money."

Another in charge of a 42 bed hospital in a town in New York State says: "While our hospital is a city institution, we serve a large area of other towns and counties. More than half our cases are pay patients, the rest are county or town cases and we receive payment for them from the state."

From the superintendent of a 40 bed hospital in a town in Wisconsin, with a population of 4000, comes this explanation: "Some years ago the city received the hospital grounds as a bequest. In 1930 a few citizens organized a hospital association to which the city and county donated \$60,000 and \$20,000, respectively, for the erection of a hospital building. The association then asked the public for contributions for the furnishings of the hospital. When the hospital was completed, the members of the association elected a board of seven trustees. The mayor, one alderman appointed by the mayor and the chairman of the county board were asked to act as honorary members

with full trustee privileges. . . . The county pays the hospital for the care of indigent patients at a rate agreed upon, which is a little less than ward rates."

The method of establishing and operating this hospital illustrates the use of both public and private funds in hospital construction and maintenance. It also provides a good example of cooperation between private citizens and the public officials of their community. It is probable that in these smaller communities the board of trustees is made up of essentially the same people as those who would have been members of the board of a voluntary hospital, had one been in existence. Moreover, in many cases, support is derived just about as extensively from payments by private patients as it would be if the hospital were under voluntary control. The chief difference is that in the governmental hospital the deficit is usually made up from tax funds instead of from private sources. There is, however, an increasing tendency among voluntary hospitals to expect governmental authorities to pay at least a share of the costs of hospitalizing persons who are public charges. The recently published statement of the American Hospital Association and the American Public Welfare Association discusses this policy.

Differences Are in Degree

In regard to the economic groups of patients served and the basis of financial support, it thus appears that outside of the large cities, outside of California and perhaps of a few other states, no marked difference usually exists between the local voluntary hospital and the local governmental hospital furnishing general care. The differences are in degree rather than in substance. The basic fact will, however, be remembered that the total number of American communities, outside of the large cities, in which local governmental hospitals exist is relatively small and that in the great majority of middle-sized or small communities which have hospitals at all, these are voluntary or proprietary institutions.

This study makes it evident, nevertheless, that there is a goodly number of American communities in

which a city or county hospital does perform the function of medical care to all economic groups and serves all or most of the privately practicing physicians in the community. Proposals for the development of local governmental hospitals in areas not now provided with any hospitals will find a number of existing patterns. Such patterns can be had from places in which the local governmental hospital is the only one in the area, and also from those wherein voluntary hospitals exist side by side with the governmental.

An American Way

Would not a hospital established and operated under such conditions, either by the local government or by a voluntary agency, be an American way of providing medical and hospital service for communities which are now largely or completely without the resources of modern medicine? To develop such hospitals both voluntary and governmental efforts are in order. Either might go it alone in some localities; or local governing authorities, local representatives of medicine, agriculture, industry, philanthropy and individuals able to pay for their care might join hands in establishment and operation.

In communities in which, because of poverty or sparse population, neither local tax funds, private resources nor local professional skill are sufficient for the erection and operation of a hospital, the technical or financial aid of the state and federal governments is called for. Good roads and up-to-date ambulances may make it possible to transport patients considerable distances to hospitals in large cities but that does not solve the local problem. A local hospital, rightly organized and maintained on sound professional and financial standards, has value not only to the patients cared for in its beds but to the total medical and health service of its area. It should be able to draw specialized services from larger centers and also to send selected cases thereto for diagnosis or treatment. However, it cannot be displaced by the larger centers without deteriorating the general medical care of its locality and lowering the level of American rural life.

If the patient or the relatives desire to inspect accommodations before signing a contract, the room clerk should be happy to oblige since he is the sales officer of the hospital. In the photograph the patient is presenting a hospital care insurance card.

THE admission of each new patient to the hospital and the particular circumstances surrounding his entrance inevitably raise certain problems that must be solved with tact and diplomacy by the admitting officer.

Frequently physicians are irritated because the admission clerk insists upon having a diagnosis of a case before she is willing to assign accommodations. This irritation is justified since the physician usually telephones in the hearing of several anxious relatives who are alarmed at the mention of typhoid fever, meningitis or appendicitis. Ordinarily, the statement that the patient is being sent in for study or for the treatment of some indefinite ailment should be sufficient.

If the patient for any reason must delay admission for several days, the question arises as to whether the hospital should make reservations in advance. This is usually permitted in the case of private or semiprivate rooms, although some hospitals enforce the rule that such rooms may not be held longer than six hours unless a charge is made therefor. All such rules, of course, depend upon the number and type of hospital beds vacant, the condition of the patient applying and, to some extent, upon the degree to which the physician in question supports the institution. Of course, the admission of a critically ill patient should never be delayed and even a reserved room should be immediately put at his disposal.

If reservations are made some time in advance, as in the case of the maternity patient, a request for a reduction in room rate is sometimes made because space of the type engaged is unavailable at the moment. The hospital should always keep its promises even though a more expensive

accommodation than was requested must be temporarily assigned to meet a previous reservation.

The perfect admitting clerk is yet to be discovered. There is probably no clerk at whose door the charge of favoritism has not been placed on one or more occasions by a staff member who could not obtain the immediate acceptance of a ward patient. The problem of handling the admission of the patients of the courtesy staff is difficult. The admitting officer of a large hospital is not always acquainted with the individual members of the courtesy staff. Occasionally such physicians have been known to adopt slightly devious methods in order to obtain admission for their patients. Of course, an alert hospital administrator soon learns the way to circumvent such improper behavior. Perhaps the reason why most admission clerks are instructed to require a diagnosis lies in the necessity for preventing the admission of patients for treatment

of a disease for which the institution has no accommodations and who would be refused if the diagnosis were frankly stated.

Another difficult problem centers about the admission of patients to endowed rooms. In many institutions such individuals assume the classification of ward patients to whom the staff men may not send a bill. Some of these patients are patently economically able to occupy private rooms and when the physician realizes the patient's ability to pay he is naturally displeased.

Not directly applicable to this problem but sufficiently closely allied to justify its mention here is the restriction often placed upon specialty admissions insofar as staff assignment is concerned. It is wholly proper for hospitals to endeavor to prevent surgeons from treating ward medical cases and even to discourage the mixing of specialties by full staff men. This is difficult to do in the private suite but comparatively easy



The Patient Arrives

JOSEPH C. DOANE, M.D.

in the wards. The admission clerk should know whether a physician is permitted to admit to his own service a patient who requires major surgery. To this end the clerk should have a rating card that informs her as to the privileges allowed to each physician practicing in the institution. For example, one doctor has an "A" rating that gives him full surgical privileges; another may have a "B" rating that allows him to operate only with the knowledge and consent of his chief, while a third may have a "C" rating that permits him to operate only in the chief's presence.

It is the duty of the hospital to provide not only adequate bed facilities but also the kind of medical or surgical care that each case requires. If the inquiring physician does not have the type of privileges that permit him to care for a patient someone in the admitting office should be able to suggest a solution to the problem. This may be achieved by a consultation with a staff man or by admitting the patient wholly upon the latter's service.

Ward patients may not request a specific doctor. Incidentally, it is often set down as a definite rule that patients who have been treated without charge by a staff man in the ward may not call a consultant and pay him for his services. This is wholly fair and right and when such a request is made the patient or his family should be informed that private cases may call the physician of their choice if he is in good standing but that ward patients must be under the supervision of the staff physician.

Ward gynecologic cases usually are not assigned to surgeons and, on the other hand, in most departmentalized hospitals general surgeons do not perform pelvic operations, craniotomies or tonsillectomies. Certain exceptions are made to this rule whereby a surgeon who for many years has operated upon private patients referred to him by a general practitioner may receive direct referrals of ward patients. Care should be exercised, however, to prevent too great confusion in the departmentalization practices of the general hospital.

Many hospitals still feel, and perhaps wisely so, that it is best for them to maintain an ambulance for

the transportation of private patients. Others have learned that they can purchase ambulance service more cheaply than they can provide it. Some believe that special entrances for private patients are unjustifiable, that they represent an undemocratic trend. Nevertheless, it is probably best to provide this convenience for the private clientele whenever possible. If patients pay for privacy, they certainly should be given it. It is hardly fair, moreover, for maternity patients to be required to pass through crowded waiting rooms on their way to the beds assigned to them.

The interviewing room where contracts are signed and where rates are

This is the first of two articles in which Doctor Doane will discuss the admission, early diagnosis, treatment and eventual discharge of the patient

explained should be secluded and tastefully furnished and should represent a fair sample of the orderliness and courtesy that are to be expected of the hospital. The hotel counter method of assigning rooms should long ago have been abolished. If the patient or his relatives desire to inspect accommodations before signing a contract, the room clerk should be happy to oblige since she is the sales officer of the hospital. She should be thoroughly familiar with the accommodations that she offers to the public. In order to spare a sensitive and apprehensive patient any embarrassment, his economic and personal history should be taken in privacy and after he has had time to settle quietly down into the hospital routine.

From an economic angle, the method of admitting a ward patient is highly important. The hospital that blithely places the ward patient in bed before finding out who will pay the bills is likely to lose many thousands of dollars a year. Hence it is a good policy, when a physician calls the hospital to obtain the admis-

sion of an elective case, for the admitting clerk to request the presence in her office of the individual's nearest relatives before the ambulance is dispatched.

It is also a wise practice for the chief resident physician or some medical officer of the hospital to study the medical urgency of patients referred from the dispensary before they are admitted. Often young and aggressive dispensary surgeons request the admission for operation of patients suffering from conditions which, because of the patient's age or economic station, should be left alone. This admission clinic is the implement by which a sorting of medical needs can best be accomplished.

Some day, somewhere, will be discovered a hospital that takes the time to explain to incoming patients the practical regulations of everyday institutional life. Such an institution will not take for granted that all friends and relatives know how and where to address letters, send flowers, pay their bills and obtain the discharge of the patient. Information concerning meal hours and visitors will be immediately available and a frank statement as to the expense of extras, such as x-ray examinations and electrocardiography, will be put into the hands of the patient upon his arrival. This ideal institution will even furnish such information as the method of obtaining a radio, the hours during which it may be played and the means by which clothes may be pressed and magazines and books purchased.

Assists Elementary School

When a girl reaches seventh grade it's time she learned how to take care of a baby. That was the idea in the minds of administrators of Southwark School and Mount Sinai Hospital, Philadelphia.

A lecture demonstration series in infant care began in early May in the conference hall of Mount Sinai Hospital for the benefit of elementary school girls.

Dr. Max Cantor explained the essential facts needed for feeding, bathing and "mothering" a baby properly. A hospital nurse demonstrated on a diminutive subject.

Better Training for Negroes

IF BETTER facilities were available for the training of Negro physicians and nurses these professional workers would undoubtedly be able to render a greater measure of service to the members of their own race. Moreover, the advantages accruing from the improvement of the Negro health would be of benefit to the white population.

An example will serve to illustrate the disadvantages under which Negro physicians, medical students and nurses usually operate. Freedmen's Hospital in Washington, D. C., is devoted almost exclusively to the treatment of Negroes, although, under the terms of its charter, it may extend its services to transient and resident whites as well. The institution is staffed by Negro physicians and nurses and serves as the teaching center for the medical school of Howard University, one of the two Negro medical schools in the United States.

Antituberculosis Training Needed

The tuberculosis death rate among Negroes in Washington is abnormally high. In the calendar year 1937, for example, the death rate from this disease among Negroes was 227.8 per hundred thousand population while among whites it was 45.0 per hundred thousand. Negroes comprise approximately 27 per cent of the population of the community. Obviously, it would be highly advantageous under the circumstances for Negro medical students, physicians and nurses to be thoroughly familiar with the manifestations, diagnosis and treatment of a disease that exacts so heavy a toll among the people of their own race. However, clinical facilities have heretofore been largely lacking, the result being a lamentable lack of practical knowledge and experience with the disease. Fortunately, however, the serious implications of this defect were recognized, even though tardily, and steps have been taken to provide a 150 bed

tuberculosis hospital in the Freedmen's group. Plans have been definitely made for the construction and operation of this building, which will rank with the best of its kind and which will be available in the near future.

What has been said concerning the need for training and experience in handling tuberculous patients applies equally to all phases of medicine and public health. It is estimated that in 1937 there were 4000 Negro physicians licensed to practice medicine in the United States. In order to obtain these licenses the physicians must have served acceptable internships in accredited hospitals. Since only half of the 200 Negro hospitals are registered by the American Medical Association and since white institutions utilize Negro interns to a limited extent or not at all, the difficulty of acquiring adequate practical training and experience becomes apparent.

Whereas Negroes comprise approximately one tenth of the total population of the United States there are but two Negro medical schools, Howard in Washington and Meharry in Nashville, as compared with some 70 schools conducted primarily for white medical students. There are some 200 Negro hospitals, many of them small and not registered, while there are approximately 6000 institutions for white patients, to many of which Negro patients are admitted for treatment but to which Negro physicians are not admitted for practice or instruction.

Short Courses Sought, Too

When the ratios of white and Negro physicians to members of their own races are considered it is found that there is one white physician to 744 white persons and one Negro physician to 3000 Negroes. Dr. Numa P. G. Adams, dean of the school of medicine at Howard University, states that there is no evidence of a demand for a considerable

ROBERT OLESEN, M.D.

increase of Negro medical students but a definite need for improved facilities for undergraduate and graduate medical instruction. Better educational opportunities for interns and practical short courses for Negro practitioners also loom large as essential needs.

According to the National League of Nursing Education there are only 24 accredited nursing schools for Negro students. In addition there is one school in Richmond, Va., for the training of Negro public health nurses. There are probably 6000 Negro nurses in the United States, 604 of whom are engaged in public health work and who are rendering excellent service. The ratio of all nurses, bedside and public health, to the general population is one white nurse to 306 white persons and one Negro nurse to 2076 Negroes.

Great Need Is for Experience

The present discussion is a plea not so much for additional hospital and nursing facilities and improved instruction, as for greater opportunities for the gaining of experience by qualified Negroes. If the National Health Program materializes, in whole or in part, there will be need for considerable additional personnel. Negro physicians, dentists and nurses should play an important part in the expansion of medical care services. Well-trained Negroes have demonstrated beyond a doubt their ability to render efficient service. However, to become efficient they must be able to obtain adequate training and this can be received only in registered hospitals, accredited nursing schools and efficient postgraduate courses. These objectives may be realized either by increasing the efficiency of existing Negro hospitals or by designating portions of white hospitals for the care of Negro patients and by providing better training for Negro medical students, physicians and nurses.

Doctor Olesen is assistant surgeon general of the U. S. Public Health Service.

Psychiatric Preparation

THE total functioning person must be considered in the preparation of surgical patients if optimum conditions are to exist before, during and after operation. This fact is well known to men prominent in the field of surgery.

It has been noted by several authorities that postoperative psychiatric complications develop only in those persons who were suffering from some type of maladjustment in the preoperative period or who had some operation that involved the brain or genital system.

In spite of the apparent understanding of psychiatric complications, little has been suggested to prevent their development. The literature contains numerous excellent papers that discuss every possible preparation of the patient's body for the surgical experience but in most instances these papers completely neglect the emotional trauma and the personality adjustment required to face a strange and, to the patient's way of thinking, hazardous procedure.

The ritualistic care with which the offending body segment is shaved, scrubbed and decorated with antiseptics does little to allay the patient's anxiety. The masked anesthetist with a battery of strange bottles and gauges increases the feeling of strangeness. If this display is accompanied by a few thoughtless or facetious remarks the most stable individual undoubtedly will show a great deal of justifiable apprehension and fear.

Every patient who must undergo surgery should be given a careful explanation of the reasons for operating, the results anticipated and the alterations in physiological function expected. This procedure removes the element of uncertainty in the patient's mind and obviates many of the usual misgivings. Each step in preparation for the anesthetic and the operation should be carefully explained by a competent nurse or



LONG BEFORE THE SURGEONS PREPARE . . .

physician. Thoughtless or facetious remarks concerning the operation or the expected outcome should be avoided.

The relatives, too, should be cautioned against expressing undue concern prior to the operation and during the immediate postoperative period when the patient is still somewhat confused from the anesthetics and analgesics administered. In most stable persons these simple measures are sufficient to ensure an uneventful convalescent period insofar as personality functioning is concerned.

Some individuals will require special care and attention during the preoperative period if complications are to be minimized. These cases are not always easy to recognize and, when practicable, a careful study of the patient's personality prior to operation will enable one to anticipate and prevent many undesirable reactions. Persons who are prone to develop postoperative psychiatric complications may be roughly divided into four groups:

1. Individuals who are suffering from some organic disease other than

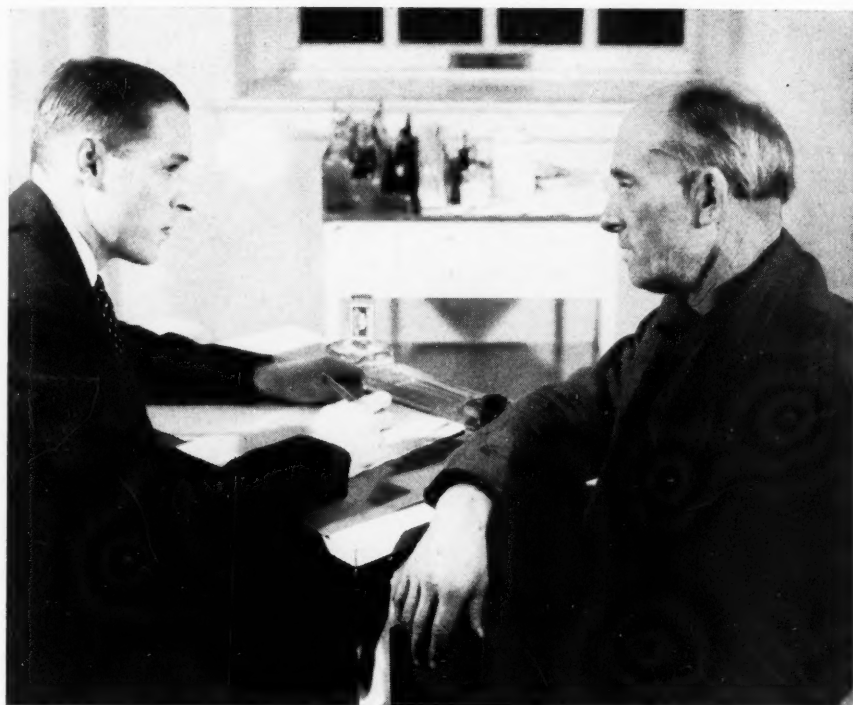
that for which they are being operated upon. In this group organic damage to the central nervous system in the form of cerebral arteriosclerosis, neurosyphilis or undetected brain tumors are capable of producing serious complications if not evaluated and treated prior to surgical intervention in some other portion of the body.

In genito-urinary and in accident cases operation may be necessary in the face of known cerebral arteriosclerosis, but even in these cases the clinical course will be more satisfactory if all the factors of body functioning are considered in the choice of operation, type of anesthesia and management of sedatives. In many instances careful physical and neurologic examinations prior to operation will reveal the presence of organic features.

A person who shows any of the following symptoms should be carefully studied for organic disease of the central nervous system: (1) a long record of effective life performance followed by a striking decline with character and personality

of the Surgical Patient

JACK R.
EWALT, M.D.



THE SURGICAL PATIENT MUST BE PREPARED

change; (2) disturbance of memory, retention and judgment; (3) irritability and loss of emotional control; (4) disturbance in thinking processes, slowing, confusion and periods of aphasia, and (5) persistent complaint of headache and dizziness.

2. Patients suffering from exogenous toxic reactions must be thoroughly detoxified before operation if severe delirious episodes are to be avoided. Alcohol intoxication and bromidism are the most common offenders and, when accompanied by an avitaminotic state, often give rise to severe and prolonged psychotic reactions. A careful inquiry for toxic factors should be made in all prospective surgical patients. The presence of early toxic symptoms warrants postponement of all but the most imperative surgical procedures until the patient can be detoxified and rehabilitated.

The following symptoms suggest a toxic reaction and necessitate a thorough investigation for causative factors: (1) disturbance in the level of consciousness; (2) fear, anxiety, delusional and hallucinatory experi-

ences (symptoms are more severe at night), and (3) physical and laboratory evidence of cardiovascular failure, anemia, avitaminosis, drug intoxication, chronic alcoholism or acute and chronic infections.

In patients scheduled for operation to relieve a toxic state, such as an empyema, the toxic symptoms must be noted and evaluated in the choice of anesthesia and sedation if postoperative difficulties are to be avoided.

3. Many individuals suffer from conflict and anxiety over the nature of the proposed operation. These worries are particularly common in operations involving the eyes and genital organs and in those involving disfigurement of the body, such as amputations, scarring of the face or amputation of breast tissue in women. The careful surgeon will be wise to discuss fully the operation involved, its necessity and the possibility of continued physiologic function after the surgery. These precautions are especially necessary in persons who are to have some type of pelvic or genital surgery because many persons have erroneous beliefs

concerning the rôle played by the various pelvic structures in personal charm, mental stability and attractiveness for the opposite sex. A few words of explanation prior to operation may avoid the necessity for weeks of prolonged treatment later in life.

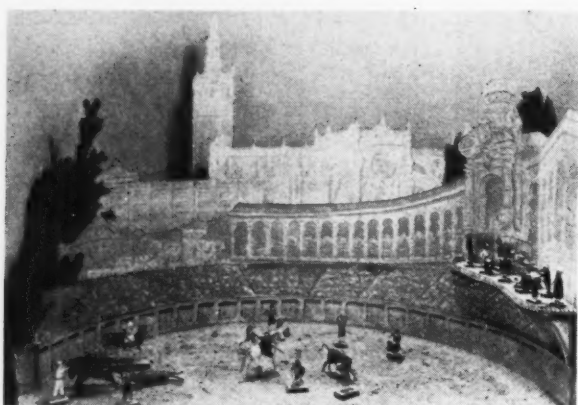
4. The most important group of patients to recognize preoperatively are those who present definite functional personality problems. These symptoms may vary from mild anxiety and tension states to fully developed psychoses. Such patients often have psychogenic complaints that simulate surgical conditions and such factors should be carefully investigated before any elective type of surgery is undertaken. The patient with a disease that requires prompt surgical intervention should be seen in consultation with a psychiatrist and the preoperative and postoperative management planned in terms of his psychotic state.

Whenever it is possible the surgery should be postponed until the patient has undergone a period of treatment and is making a better adjustment to ordinary life situations.

Patients who present any of the symptom complexes of such abnormal states as psychoneurotic, manic-depressive, schizophrenic, psychopathic or paranoid reactions or mental deficiency should have a thorough psychobiologic study before any elective surgical procedure is undertaken.

The physician who suspects conflict material in his patient but is unable to demonstrate it will often find an association motor study of great benefit. In performing this test most patients will show some form of pathologic reaction to the critical stimulus words. This gives a graphic record that may be used for demonstration purposes to the patient and will materially shorten the investigative period.

Doctor Ewalt is resident psychiatrist at Colorado Psychopathic Hospital, Denver.



Story Book Pals

MABEL W. BINNER

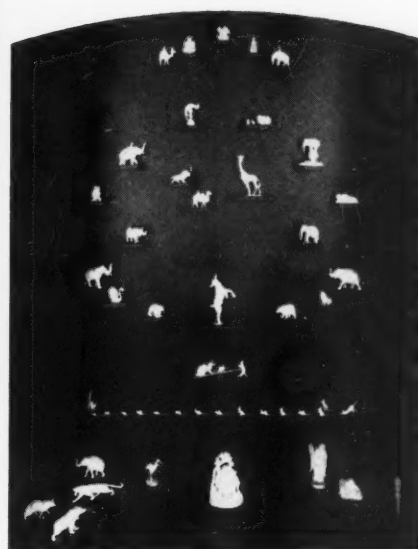
FOR several years the Children's Memorial Hospital in Chicago has emphasized the necessity for providing as happy and peaceful an atmosphere as it is possible to achieve in an institution. The confusion in a clinic and the journey to operating room or x-ray department may be terrifying to children. Their reactions are carefully watched, for a conversation carelessly held by adults in the presence of the little patient may produce anxieties that not only delay his convalescence but may produce lasting scars.

The administrator must be constantly on the alert to find means of counteracting these conditions. The personnel is carefully selected in all departments, not only because of its ability and general fitness to do specific tasks but also because of its liking for children.

Any link between the world that the child has known and the mysterious unknown clinic and hospital helps to put him at ease and to give him the sense of security necessary to happy childhood. Attractive, bright colored clothing instead of the hospital nightshirt, pleasant grade and kindergarten teachers, a cheery librarian and her books and the much sought after "play lady," all are invaluable aids found in many children's hospitals or children's wards.

In our program there was one serious need. Lack of space and funds made it impossible to develop any plan for those children who were waiting to be admitted to the hospital. This produced a particular problem on the days when groups of patients were being admitted for surgery. At times one terrified child in the group would arouse the fears of 15 or 20 others.

When Mrs. James Ward Thorne, whose miniature rooms created much attention at the Chicago and San



Come to Hospital

**Superintendent, Children's
Memorial Hospital, Chicago**

Francisco expositions, offered to present our hospital with 18 dioramas depicting the stories all children love—"Winnie the Pooh," "Peter Rabbit" and others—we knew they deserved space such as the hospital did not possess. We also knew that the one point at which they would prove a veritable godsend was the crowded, badly lighted corridor down which so many children pass on stretchers and in wheel chairs on the way to the x-ray department and the amphitheater and along which the patients wait for admission to the hospital wards.

Mrs. Thorne was in complete sympathy with the suggested location. The dioramas have been placed along both sides of the corridor. They are at stretcher height, so that they can be seen easily by the patients as they are wheeled past. The universal appeal of the dioramas was well demonstrated when a tiny child and a burly policeman, who was bent almost double, were seen chuckling together over one of these scenes.

Mrs. Thorne has acquired a comprehensive collection of tiny articles during years of travel. In the Peter Rabbit series the figures are Viennese bronze, representing numerous characters in Beatrice Potter's enchanting set of books about Peter Rabbit and his friends. The backgrounds are worked out in accordance with Miss Potter's script and the dioramas tell stories.

Particularly interesting to children are the "Trip Around the World" and the "Circus." The first is a shadow box with a celestial globe in the center surrounded by small shelves holding tiny articles brought from all parts of the world. These are characteristic of the countries they represent. The circus tent has bronze animals in the ring performing to the music of a cat band and a mouse band.



International Hospital

Tuesday, September 19

8:00-10:00 a.m.—Registration.
10:00-12:00 m.—Business sessions of study committees.
2:00-4:30 p.m.—Joint conference of all study committees.
8:00-10:00 p.m.—First plenary session, Dr. Malcolm T. MacEachern, President, I.H.A., presiding.
Pageant of Nations portraying care of the patient, sponsored by the nurses of Canada.
Introduction of officers and distinguished guests.
Official welcomes.
Responses.
"World Unity in Relief of Suffering," Doctor MacEachern.
10:00-11:00 p.m.—Formal reception for delegates and guests.

Wednesday, September 20
Second Plenary Session, 9 a.m.

World-Wide Advances in Hospital Construction

"Points of View in the Planning of Large Hospitals, the Use of Material and the Technical Installation," C. E. Elcock, F.R.I.B.A., Architect, London.
"The Hospital as a Masterpiece of the Architect," Monsieur Jean Walter, Paris, Architecte du Gouvernement et des Facultés de Médecine de Paris et de Lille.
"Construction of Hospitals for the Forces," Oberregierungsrat Klaje, Berlin.
"The Importance of the One Bed Ward System in the Architectural Development of the Nursing Unit and Complementary Rooms," Dr. Ing. Comm. Gaspare Lenzi, Reggente Nazionale Gruppo Ingegneri Edili Sanitari, Sindacato Nazionale Ingegneri, Rome.
"Internal Dimensions of the Hospital: Some Important Measurements," G. Birch-Lindgren, Architect, Stockholm.
"The Special Requirements of Hospital Construction in the Tropics," Carlos A. Surraco, Architect, Montevideo.
"The Influence of Climatic Conditions on Hospital Construction," A. G. Stephenson, Architect, Melbourne.
"A World-Wide Commentary on Hospital Construction," Edward F. Stevens, F.A.I.A., Architect, Boston, and Editor, "The Twentieth Century Hospital."

2-4 p.m.

Reports of Study Committees

Study Committee I, Construction: Chairman, Hermann Distel, Architect, Hamburg.
Subject: Rehabilitation of Antiquated Hospitals.
Study Committee XXI, Functional Conditions of Hospital Architecture: Chairman, Dr. Hans Frey, Director, Inselspital, Bern.
Report: Admission and Distribution of Patients.
Study Committee X, Hospital and Community: Chairman, Homer E. Wickenden, General Director, United Hospital Fund, New York.

Toronto, September 19 to 23, Royal York Hotel

Report: Methods and Possibilities of Financing Hospital Work.
Study Committee XV, Press and Publicity: Chairman, Dr. A. Barthelmé, Secrétaire Général, Hospices Civils de Strasbourg, Strasbourg.
Report: Hospital Propaganda for the Patient.
Study Committee V, Legislation and Legal Questions: Chairman, Dr. J. Oster, Directeur Général des Hospices Civils de Strasbourg, Strasbourg.
Report: Main Requirements for a Code of Hospital Law.
Study Committee IX, Statistics and Nomenclature: Chairman, Dr. Ralf Zeitler, Vize-Präsident des Deutschen Gemeindetags, Berlin.

Reports: An Internationally Applicable Scheme for Drawing Up Annual Hospital Reports. A Hospital Vocabulary of 1000 Words in English, French, German, Italian and Spanish.

Study Committee XXXI, Cancerology: Chairman, Prof. Dr. A. H. Roffo, Director, Institute of Experimental Medicine, University of Buenos Aires.

Report: Uniform and Systematic Plans for Getting in Touch With and Treating Cancer Cases Through Early Diagnosis.

Study Committee XXX, Venereology: Chairman, Mrs. Neville Rolfe, O.B.E., Secretary-General, British Council of Social Hygiene, London.

Report: Hospital and Venereal Disease Patient; Edinburgh Venereal Disease Scheme in Action.

Study Committee XXXIV, The Hospital and Tuberculosis: Chairman, Prof. Jaroslav Jedlicka, Professor der Phthiseologie und Vorstand des Universitätsinstitutes für das Studium der Tuberkulose an der Karls-Universität Prag, Prague.

Report: The Hospital in the Fight Against Tuberculosis.

Study Committee XIII, Hygiene, Climatology and the Destruction of Harmful Organisms: Chairman, Prof. Dr. Cramarossa, Direttore dell'Ufficio di Igiene del Governatorato di Roma, Rome.

Report: Fundamentals of Hospital Hygiene.

4:30-6 p.m.

Observation and Study Tours of Toronto Hospitals.

7 p.m.

Private Dinners

Thursday, September 21

Third Plenary Session, 9 a.m.—12 m.

Place of Hospital in Community

"What Rational Care of the People's Health Demands of the Hospital," Dr. Innes H. Pearce, Pioneer Health Centre, Peckham, London.
"A World Survey of Church Hospitals," Dr. Newton E. Davis, Executive Secretary, Board of Hospitals, Homes and Deaconess Work, Methodist Episcopal Church, Columbus, Ohio.
"The Hospital and Insurance for Health," Amtsleiter H. Althaus, Hauptamt für Volkswohlfahrt, Berlin.



Dr. G. Harvey Agnew and Dr. Malcolm T. MacEachern

"Hospital, Publicity and Press," Prof. Nicola Sforza, Primario Medico, Ospedale San Spirito, Rome.

"Social Service Care of the Patient Before, During and After Hospital Care," Doctor Ripkova, Krankenhaus Bata, Zlin.

"Hospital in the Fight Against Cancer," Prof. Dr. A. H. Roffo, Director, Institute of Experimental Medicine, University of Buenos Aires.

"Norms in the Organization of Hospitals for the Mentally Ill," Dr. Baltazar Caravedo, Lima; Director, Victor Larco Herrera Mental Hospital, Lima.

"Planning for the Chronic Patient," Dr. E. M. Bluestone, Director, Montefiore Hospital for Chronic Diseases, New York.

2-4 p.m.

Reports of Study Committees

Study Committee XXII, Equipment and Furnishings for the Care of the Patient: Chairman, Dr. Malcolm T. MacEachern, Associate Director, American College of Surgeons, Chicago.

Report: Ideal Contents and Arrangement of the Sickroom.

Study Committee II, Sanitary Technics and the Economics of Power Production and Supply: Chairman, Dr. Ing. habil. Adolf Heilmann, Professor u. Stadtbaurat a.D., Berlin-Charlottenburg.

Report: Heating the Hospital by Radiator, Panel or Floor.

Association Program

The Rt. Hon. Lord Tweedsmuir,
Governor-General of Canada, Patron



MacEachern talk over the I. H. A. program

Study Committee XXXVII, Kitchen, Laundry, Stores: Chairman, Miss Marion ffoulkes-Pritchard, Matron, Boksborg-Benoni Hospital, Boksborg, Transvaal.

Report: Electrical Equipment in Kitchen, Laundry and Stores.

Study Committee XX, General Organization of Diagnostic and Preventive Institutions Connected With Hospitals: Chairman, Dr. Pierre Depage, Directeur de la Clinique Antoine Depage, Brussels.

Report: General Organization of Diagnostic and Preventive Institutions Connected With Hospitals.

Study Committee XI, Air Raid Precautions: Chairman, Oberst Dr. J. Thomann, Eidgenössischer Armeepotheker, Bern.

Report: Practical Training in Air Raid Precautions.

Study Committee XXXVI, Transport of Patients: Chairman, Sydney Lamb, M.B.E., Secretary, Merseyside Hospitals Council, Liverpool.

Report: Transport of Patients.

Study Committee XXIV, Internal Medicine: Chairman, Dr. Paul Ghalioungi, Heliopolis, Egypt.

Report: Place and Importance of Internal Medicine in Work of Hospital.

Study Committee XXIX, Pediatrics: Chairman, Prof. Dr. Wladislaw Szenajch, Directeur de la Clinique Infantile Universitaire, Warsaw.

Report: Social Service in the Children's Hospital.

Study Committee XVI, Nursing: Chairman, Dr. P. H. van Roojen, Geneesheer-Directeur van de Gemeenteziekenhuis, Gravenhage, Holland.

Report: Nursing Staff of the Hospital.

Study Committee XVII, Spiritual Care of the Sick: Chairman, Pralat Dr. Kreutz, Präsident des Deutschen Caritasverbandes, Werthmannhaus, Freiburg i.Br.

Report: Spiritual Care of the Sick and the Administration of the Hospital.

Study Committee XXXVIII, Preventive Possibilities of the Hospital: Chairman-ship, New Zealand.

Report: Duty of Hospital in Preventing Disease.

4:30—6 p.m.

Observation and Study Tours of Toronto Hospitals.

7—10 p.m.

Fellowship Dinner Under Auspices of Toronto Committee on Arrangements, Dr. William S. Caldwell, Toronto, Toastmaster.

Brief Addresses.

Motion Pictures:

"Good Hospital Care" (sound), produced by Dr. Malcolm T. MacEachern, Chicago.

"Behind the Scenes," produced by George U. Wood, Superintendent, Peralta Hospital, Oakland, Calif.

"Three Years a Student Nurse," produced by Western Hospital, Toronto.

"Travelogue: A Trip Through Canada," produced by Publicity Department of the Canadian Government.

Entertainment.

Friday, September 22

Fourth Plenary Session, 9 a.m.—12 m.

Hospital Organization and Management

"The Training of the Hospital Administrator," Dr. G. Harvey Agnew, Secretary, Department of Hospital Service, Canadian Medical Association, Toronto; President, American Hospital Association.

"Plan of Organization and Distribution of Authority," Capt. J. E. Stone, Consultant on Hospital Finance to King Edward's Hospital Fund for London, Birmingham.

"The Nurse's Part in Hospital Administration and Management,"* Miss Bergljot Larsson, President, Norwegian Hospital Association; Superintendent, Norwegian Nurses' Association, Oslo.

"Hospital Administration and Management as Part of a Planned National Economy," J. Myburgh, Secretary-Superintendent, Boksborg-Benoni Hospital, Boksborg, Transvaal.

"Organization and Management of the Food Service in the Hospital," Dr. Kate Daum, Director of Nutrition, University of Iowa Hospitals, Iowa City.

"Governmental Control Through Laws and Regulations of the Hospital and Its Work," Dr. Konrad Orzechowski, Presi-

*This presentation may be made by a substitute speaker.

dent, Polish Hospital Association, Warsaw.

"The Hospital Viewed as a Business Enterprise," Finanzinspektor Bruggmann, Zurich.

"Annual Reports," Dr. A. Barthelmé, Secrétaire-Général, Hospices Civils de Strasbourg, Strasbourg.

12:30—2 p.m.

Luncheon Under Auspices of American College of Hospital Administrators. Dr. Robin C. Buerki, President, American College of Hospital Administrators, Chicago, presiding.

Brief Addresses on the Educational Aspect of Hospital Administration.

Dr. G. Harvey Agnew, President, American Hospital Association.

Dr. A. C. Bachmeyer, Director, University of Chicago Clinics.

Dr. Malcolm T. MacEachern, President, International Hospital Association.

Miss Ada Belle McCleery, Superintendent, Evanston Hospital, Evanston, Ill.

Capt. J. E. Stone, Consultant on Hospital Finance, King Edward's Hospital Fund for London, Birmingham.

General Discussion.

2—4 p.m.

Reports of Study Committees

Study Committee III, Administration and Management: Chairman, Capt. J. E. Stone, Consultant on Hospital Finance, King Edward's Hospital Fund for London, Birmingham.

Report: Systematic Organization of Hospital Activities With a View to Increasing Income and Decreasing Expenditure.

Study Committee VIII, Personnel: Chairman, C. A. W. Roberts, Manager, Walton Hospital, Liverpool.

Report: Staff Welfare.

Study Committee VI, Care of the Patient in the Hospital: Chairman, Dr. W. Alter, Geheimer Regierungs- und Medizinalrat, Buchschlag, Hessen, Germany.

Report: Essential Requirements of Patient as Regards Hospital Construction, Equipment and Service.

Study Committee XXIII, General Problems of Medical Service in the Hospital: Chairman, Dr. J. Hekman, Geneesheer-Directeur van het Gemeenteziekenhuis aan den Bergweg, Rotterdam.

Report: Relationship Between the Architectural Type and Staff Required for a Hospital.

Study Committee XXV, Surgery: Chairman, Dr. B. Albert, Primar, Krankenhaus Bata, Zlin.

Report: Surgical Section in General Hospital.

Study Committee XXVI, Obstetrics and Gynecology: Chairman, Prof. Dr. Frans Daels, Director, University Hospital for Women, Ghent.

Report: Delimitation of the Scope of Obstetric Work in Respect to Other Branches of Hospital Work.

Study Committee XIV, Radiology and Its Requirements: Chairman, Prof. Dr. Hans Holfelder, Direktor des Strahlen-Instituts der Universität, Frankfurt-am-Main.

Report: Serial Roentgenography in the Hospital.

(Continued on page 118)

Speaking for

WILLIAM O. RICE, M.D.

A HOSPITAL report should be made so attractive that it will command the appreciative attention of the thousands of people in the communities it serves. This is a matter that is distinctly up to the hospital executive who is responsible for its publication.

Put yourself in the position of the average business man when he receives your report. The same mail probably brings him modern, colorful travel booklets and catalogs with which your annual report must compete for attention.

Mr. Average Citizen may be much interested in the splendid work the local hospital is doing to better the health of people but, if he receives a booklet of 100 or more pages, clad in dull, uninviting, drab covers, with its contents printed in small type and devoted largely to dry, statistical tables, he can hardly be expected to tax his eyes struggling to read through such a mass of material.

What each recipient of your annual report should receive is a well-

illustrated human document. The pages should attract the eye and the ideas should be set down in simple language that anyone can understand. The use of bright attractive covers, plenty of human interest pictures and well-arranged, easily read pages will effect great improvement in the old-fashioned hospital report. A livelier report will create increased interest in the hospital's work and will induce more gifts, bequests and endowments.

Every hospital superintendent and every board of trustees face the problem of advising the community of the work of the institution they represent through the medium of a printed annual report. Hospital executives and trustees are anxious to obtain the maximum amount of good will and interest for the expenditure involved. They should be willing to pay a little more, if necessary, for a cheerful cover and attractively illustrated pages. A report needs halftones, reproduced from carefully made photographs, that enable the reader to visualize exactly what is being done in the various departments of the modern hospital.

Such an attractive report is the best way to show that money provided for the maintenance of the hospital is being utilized where it will do the most good for the greatest number.

Illustrated front and back covers or special statements displayed on the end papers offer excellent opportunities to dramatize the activities of the hospital. Such publicity devices can be just as advantageously used to create reader interest as they can in the best selling books. Often, too, a slip folded over the front cover may be utilized to attract attention and to lead to the careful reading of a particular section of the report.

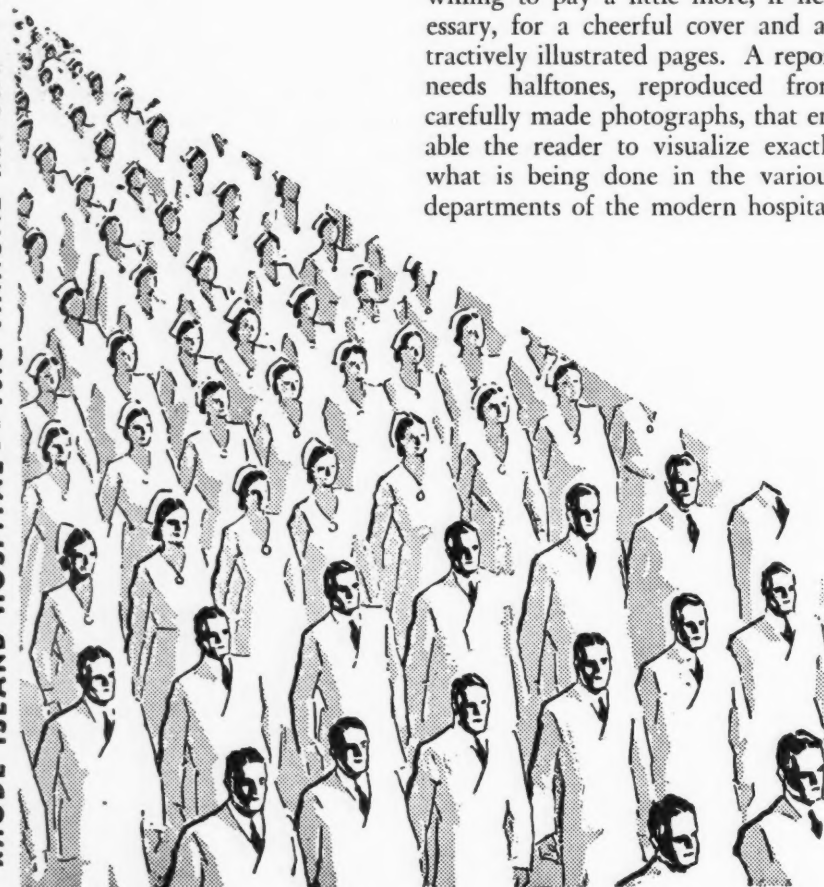
Of course, the text pages of any hospital report cannot be made to read like a story book; they do contain much of general interest, however, and it is possible to set them up in a readable type face, with the copy arranged invitingly.

Chapter headings, initial letters, display type and center headings between paragraphs should be used to break up solid pages of type. Side headings that summarize the contents of such pages at a glance are another means of improving the appearance of the report. Thumbnail sketches of various hospital activities may be used advantageously.

It is well to humanize hospital reports and to put them out in a form that is sufficiently attractive to ensure their being looked at and read. Hospitals that have once modernized their reports will not go back to the old-fashioned style. They are

A lively annual report will create new interest in hospital work and will induce more gifts, bequests and endowments. Such a report is the best way to show that money provided for maintenance is being utilized for the greatest good.

RHODE ISLAND HOSPITAL -- 73rd ANNUAL REPORT -- 1936



the Hospital

Superintendent, Rhode Island
Hospital, Providence

convinced that the increased interest in their institution that better designed and illustrated books carry has amply paid for the additional effort required and the somewhat greater expense involved.

For the reader who will run through the report and look at the pictures only, unusual captions may be written to impress him with some of the modern miracles performed by the hospital. Many a gift to a hospital has resulted from the interest aroused in some well-to-do citizen by a well-chosen caption. One spontaneous response is worth all the work put into this part of the report.

All material in the reports of the Rhode Island Hospital, Providence, is the type of truthful advertising that proves the value of taking readers into our confidence. Our reports show just what is being done throughout the hospital with funds provided by the public and the city. It may well be said that these humanized, carefully illustrated reports capitalize not on any exaggerated claims of superiority but on the faith and trust that can be put into a well-organized, highly skilled and carefully managed hospital.

Examination of the Rhode Island Hospital yearbooks will show that every effort has been put forth to make the reports of the various departments increasingly interesting, so that each one tells of the year's efforts, the results that have been obtained and plans and requirements

for its needed future expansion.

In turn, one may read of the progress made by the board of trustees, the treasurer, the superintendent, the comptroller, the superintendent of nurses, the social service workers, the occupational therapy department, the physical therapy department, the x-ray department, the librarian, the pathologist and the dental, fracture and thoracic clinics. There are included lists of physicians who have served as interns and of nursing school graduates with the latest known address of each individual. These lists have proved invaluable in enabling the hospital to keep in touch with former interns and nurse alumnae scattered all over the world.

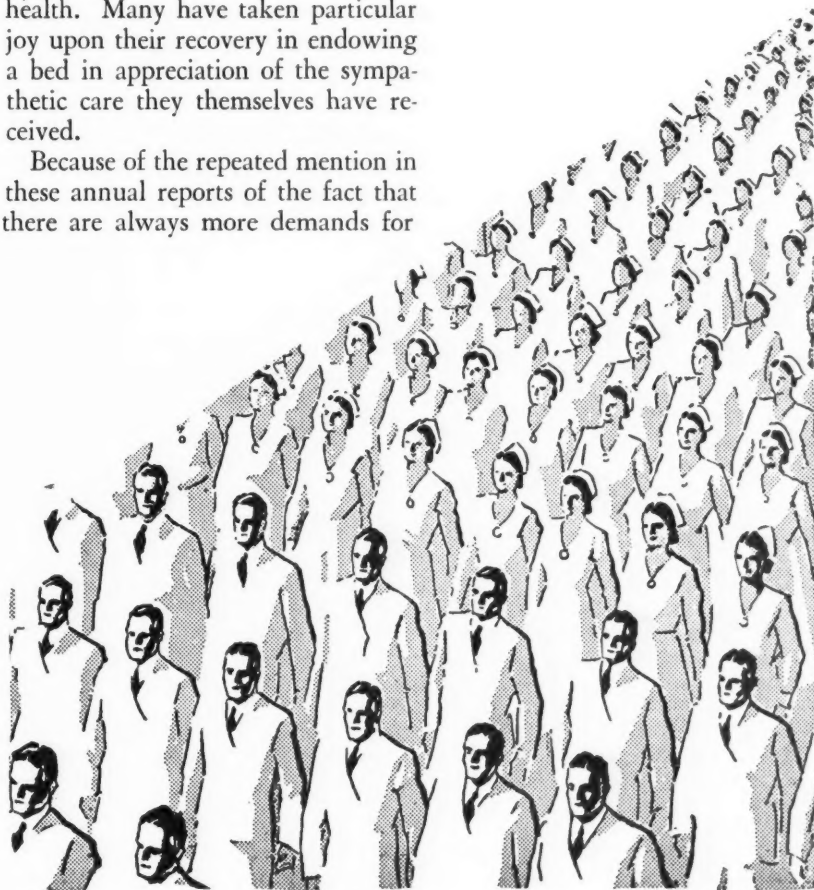
The endowment of a "permanent free bed" makes a distinct appeal to people who have spent long, weary days in the hospital battling for health. Many have taken particular joy upon their recovery in endowing a bed in appreciation of the sympathetic care they themselves have received.

Because of the repeated mention in these annual reports of the fact that there are always more demands for

such "free beds" than the hospital is able to meet, many families take this method of perpetuating the memory of a departed member. On the walls of the hospital in the main corridor, where all who pass may see, are tablets bearing the names of the donors or the names of those in whose memory they have been given.

Annual reports should be sent yearly to state and city government departments, health officials, medical and dental associations, civic, welfare and labor leaders, local newspapers, hospital magazines, educational institutions and libraries, the board of trustees and members of the hospital corporation, the medical staff, the guarantors, former interns, graduates of the nursing school and former private patients. In this way, a large number of influential and interested citizens is kept familiar with the vital assistance and service that the hospital is rendering each year to sick and injured people.

RHODE ISLAND HOSPITAL -- 73rd ANNUAL REPORT -- 1936



Hospital executives and trustees should be willing to pay a little more, if necessary, for a cheerful cover and for attractive illustrations. A report needs dramatic pictures to enable the reader to visualize exactly what is being done.

Pictorial Orthopedic Records

MARGARET M. JACKSON

IN AN orthopedic hospital every patient is a suitable subject for at least one photograph, for unlike the average medical case each patient has deformities that can be shown graphically. Usually each one has possibilities for several interesting and valuable pictures, which may include full views as well as close-ups of the affected parts. Photographs may also be taken in various positions and from different angles, depending upon the patient's abnormality and how it can be shown most accurately and instructively.

A system that has proved highly satisfactory at Gillette State Hospital for Crippled Children, St. Paul, Minn., is that of routinely photographing every patient. Pictures are taken on admission and include front, back and side views standing, and close-up views of the affected regions; or, if the patient is unable to stand, he is photographed lying down. Upon discharge, the same procedure is followed so that automatically every case has corresponding before and after treatment pictures. Also, in special cases, pictures are taken during hospitalization to show the method of treatment or the progress that is made from time to time. Special photographs are sometimes taken to portray more clearly the patient's deformity.

Poor Picture Is Misleading

Extreme care must be exercised in taking such photographs in order to give a true reproduction of the subject; otherwise, the purpose of clinical photographs is defeated, since a poor photograph is misleading and cannot be used for purposes of record. Each patient must be shown as he is; all unnecessary clothing, apparatus or equipment that would in any way detract from the subject or tend to misrepresent him should be

Miss Jackson is the medical technician at the Gillette State Hospital for Crippled Children, St. Paul, Minn.

excluded. At Gillette State Hospital the patients are photographed in plain drapes of various sizes. These cover only a small surface area and permit photographs to be taken of the entire body. The equipment includes a hospital cart, a platform and three benches. The platform has an adjustable railing on three sides which may be either raised or lowered to accommodate patients who need it for support. Benches are of different heights. These complete the equipment exclusive of the actual photographic apparatus, such as the camera and lights.

Before and After Treatment

Some spectacular before and after photographs that were taken at Gillette Hospital include club foot, cleft palate and harelip pictures. All were taken from the shortest distance possible under the existing conditions, and each pair showed clearly and accurately the condition before treatment and the result obtained.

An interesting club foot case is recorded photographically as follows: The first picture is a side view standing which shows the patient's deformity, its relationship to his body and its effect upon the subject. The second, an anterior close-up view of his legs and feet, portrays more clearly the nature of the deformity. The next picture taken at a later date corresponds in positioning to the second and shows the results of surgery. The last picture is an anterior full view of the patient at discharge. Here he is shown wearing an artificial limb and standing without support.

In some orthopedic conditions special types of photographs are taken, their purpose being to demonstrate the patient's abnormalities and limitations more clearly than could be shown in the usual close-ups, or front, back and side views. A method frequently used in cases of scoliosis and dislocation of the hips is that in

which the bony landmarks are recorded by skin markings. In scoliosis cases each dorsal and lumbar vertebra is carefully marked by means of a dot painted in superposition on the patient's skin. The back is then photographed in the center of a large frame upon which is painted a scale.

In dislocation of the hips a dot is placed over each hip and connected by a straight line. Then full back views are taken with the patient standing on both feet, on the left foot and on the right foot. In patients who have normal hips, the line connecting the dots remains horizontal, whereas in the abnormal cases the line tends to deviate from the horizontal position. By this method, pictures are produced that illustrate Trendelenburg's test and show a dislocated hip.

Another method used to show a specific condition is that employed in flexed hip cases. The patient is photographed lying on a cart with the knee of his normal extremity pulled up to his chest. This position causes his back to be in contact with the cart and the true amount of flexion in his abnormal hip is shown. This illustrates Thomas's sign.

Helpful for Displays

Torticollis cases, commonly called "wryneck," also require a special photograph. The first view taken shows the patient's head pulled to one side and is asymmetrical; in the second view the asymmetry is shown more clearly. This is accomplished by draping the patient's face and tipping the camera so that the face appears straight in the picture.

The value of such photography is for case record purposes as it provides visual evidence of existing and pre-existing conditions. Besides this, it furnishes good photographs for illustrative purposes, lantern slides and enlargements which, in turn, may be used for displays, articles, addresses and teaching.

Allies of Occupational Therapy

GERALDINE R. LERMIT

THE patient is the focal point around which all relationships revolve. From that point the place of the most recent addition to the hospital staff, the occupational therapist, is determined.

The members of any hospital staff may, generally speaking, be divided into two groups: those giving direct service to the patient and those giving indirect service. The occupational therapist, by the nature of the service involved, belongs in both of these groups and often finds in serving both that confusion results.

It has been a difficult matter for occupational therapists to serve two masters, the patient and the public; but it can be done, and it has been done by the occupational therapists at Little Green House, Rochester, Minn.

The individual of major importance with whom the occupational therapist must have initial relationship is the superintendent of the hospital. It is well to remember that hospitals must be run like any business organization. It is the place of the superintendent to be the watchdog of the treasury, responsible to that invisible and invincible body known as the board of trustees. The administrator may be sorry when he has frequently to refuse, as well as to grant, the many requests that come from all of the staff and employees. Since occupational therapists present so many strange requests, it is well for them to remember that the hospital superintendent is the one person upon whom they are dependent for the existence of their departments. Simple comprehensive records of their accomplishments, as well as their requisitions, should be reported periodically to the administrator.

Many employes who render indirect service, such as carpenters, engineers, cooks and janitors, are of importance to the successful operation of the occupational therapy department. It is well to give time in setting up cordial relations with the indispensable actors behind the

scenes. There are many more who contribute unseen service to the patient who could be included among those belonging to the indirect service group.

In comparatively few hospitals are services of the occupational therapy department used to the full extent. They will never be used fully until the physician takes the initiative in requiring occupational therapy for his patients. The nurses get directions from the doctors and the occupational therapists get suggestions. Automatically, the physician should pilot the treatment of his patients, for he has their confidence and must

The physiotherapists constitute another group giving direct service with which the occupational therapist comes into close contact. Often the treatment of both departments must be administered jointly. There is no occupational therapy training center that does not include in its course some physical therapy training.

The occupational therapist has a close relationship with the medical social workers. Broadly speaking, the occupational therapist is a medical social worker possessing special skills and technics. Sometimes the occupational therapist has a more natural and pleasant means of approach to the patient's problems than the social worker. Frequently, especially in the

First the superintendent, then the physician and the other department heads in the hospital must be enlisted if occupational therapy is to become the link that joins the patient's life in the hospital with the outside world, says the dean of the School of Occupational and Recreational Therapy, St. Louis

introduce all therapies to them if he expects the best results.

In the early days many nurses considered occupational therapy as a useless adjunct to an already crowded routine. That day has been relegated to the past and the nurse has become keenly alive to the contribution that the occupational therapist should make in the treatment of patients. Nurses frequently have become better salesmen for occupational therapy than the occupational therapists themselves. An occupational therapist is usually wise enough to know that her most useful ally, both with the physician and the patient, is the nurse. Her relations with this member of the hospital staff, who gives the most direct and intimate service to the patient, is of paramount importance. Every effort should be made to establish complete cooperation between the occupational therapy and nursing services.

home service departments, the occupational therapist will gain the confidence and case data that the medical social worker seeks. For the good of the patient close and understanding relations must exist between these two departments. Case conferences should be frequent and plans for the handling of the patients' problems made jointly.

The occupational therapist often comes closely in contact with the hospital librarian. Frequently the library adjoins or is within the occupational therapy workshop. Since occupational therapy includes mental and physical activities, books and reading constitute a most important tool in mental activity. The librarian seldom contacts the patients closely. An occasional conference between the nurse, the medical social worker, librarian and the occupational therapist may prove well worth while when the patient's hospitalization is

likely to be long and may result in more intelligent and direct therapeutic procedure. If a patient should not prescribe his own physical diet then he should not prescribe his own mental diet. Working together would appear, then, to be eminently wise on the part of the librarians, social workers and therapists under guidance of the physician.

Perhaps the most trying group of all that the occupational therapist contacts is the volunteer. Frequently the occupational therapist has the responsibility for this group. Volunteers may have difficulties in adjustments but they have a definite value in interpreting the hospital to that part of the public directly interested in hospitals. Time and energy, therefore, should be expended upon this group and plans worked out that

may turn volunteers from a possible liability into a definite asset.

Above all, the occupational therapist may be the "link" that joins the patient's life in the hospital with his life in the outside world. Mental and manual activities should be planned from an individual angle. As soon as a patient ceases to be an individual and becomes solely a case, occupational therapy ceases to contribute its full measure of therapeutic usefulness. The occupational therapist must be integrated within the hospital world as well as oriented in the world without.

With these assets an occupational therapist may establish relationships that make her work indispensable.

From a paper read at the fourteenth annual convention, Minnesota Hospital Association, Rochester.

Avoid Explosions of Anesthetics

E. A. ROVENSTINE, M.D.

THE division of anesthesia of Bellevue Hospital, New York, is particularly alert to the dangers of explosion. This article will outline the practices adopted to minimize existing hazards.

An explosion results from the combination of (1) an inflammable gas, vapor or other substance; (2) oxygen, either pure or in the air, or a gas or other substance that provides oxygen, such as nitrous oxide, and (3) a source of ignition. Anesthetics in current use in Bellevue that are inflammable and explosive include ether, ethyl chloride, vinethene and cyclopropane. Oxygen, nitrous oxide and air are employed as diluents in the respired atmospheres. All these gases support combustion. The explosive range of these drugs is set forth in the following table:

Range of Explosion		
Drug	In Air, %	In Oxygen, %
Cyclopropane	2.4 —10.3	2.45—63.1
Ether	1.85—36.5	2.1 —82.0
Vinethene	1.7 —27.0	1.85—85.5
Ethyl Chloride	4.0 —14.8	

Sources of ignition in operating rooms include: (1) any electric spark

either from static electricity or from electric circuits; (2) open flames; (3) objects heated to a temperature of at least 400°F., including cautery and lighted cigarettes, and (4) spontaneous combustion. The last named probably occurs only with gases under pressure in the presence of oil or grease.

Static electricity is the most insidious and most dangerous cause of explosion. It is created chiefly by friction between nonconducting materials. Static passes only to conductors but may pass through nonconductors. Gases and anesthetic vapors are nonconductors. The dangers from static are most potent during the winter months when the relative humidity of the air is ordinarily low. The recommended safeguards against static include: moisture in the air, the elimination of more dangerous sources and grounding to reduce the static potential between objects.

In Bellevue certain precautions are kept in mind when materials shown to be dangerous sources of static are used. During the winter months, live steam is dissipated at intervals

Doctor Rovenstine is director of the division of anesthesia, Bellevue Hospital, Department of Hospitals, New York City.

throughout the surgeries from sterilizers located adjacent to the operating rooms. Anesthesia appliances are fitted with water flow meters which ensure a completely saturated mixture within the gas machine and the respired atmosphere at all times.

Grounding is not practiced. Accidental short circuits in lights can cause serious shocks and arcing when brought in contact with grounded objects. An isoelectric state is impossible for everything in an operating room and it is generally agreed that, unless all equipment, all parts of equipment and all persons are fully and properly grounded, there will result marked differences of static potential, which may be more dangerous than with no grounding.

Additional rules that are closely followed to safeguard against anesthesia explosions are:

All anesthesia containers and appliances are left uncovered as removing cloth covers may produce static. Gas cylinders are stored in a cool well-ventilated room adjacent to the operating room. Noninflammable anesthetics are used when the cautery, electric diathermy and other spark-producing equipment are being employed.

All low voltage equipment, such as laryngoscopes, is supplied with current from low voltage batteries. Open flames, lighted cigarettes and hot plates are banned. Anesthesia appliances in use are fitted with the most modern and safe regulators, valves and water flow meters. Anesthetic gases or vapors are never warmed artificially.

Anesthetists avoid wool or silk clothing or rubber soled shoes. Woolen blankets are not moved on or off patients during the time an explosive mixture of anesthetic gases or vapors may be available for ignition. The closed carbon dioxide absorption technique is used to administer practically all anesthetics. This prevents dissipation of gases or vapors throughout the operating room, makes it possible to employ a minimum amount of inflammable agents and eliminates the need of a rapid flow of gases from cylinders.

At frequent intervals all of the surgery personnel are instructed as to the precautions to be taken against the anesthesia explosion hazard.

New Rules for Service Plans

THE following standards, established in January 1938, and revised June 1939, are an application of the principles enunciated by the American Hospital Association in 1933 and should characterize a hospital service plan that seeks the approval of the Commission on Hospital Service.

The members of the commission are: Basil C. MacLean, M.D., chairman; C. Rufus Rorem, Ph.D., C.P.A., director; R. C. Buerki, M.D.; S. S. Goldwater, M.D., and the Rt. Rev. Msgr. Maurice F. Griffin.

1. The corporate body should include adequate representation of hospitals, the medical profession and the general public. Trustees or board members of the hospital service plan should receive no remuneration for service as trustees or board members. The interests and the responsibilities of participating hospitals make it desirable that a majority of the policy-making body be representatives of hospitals.

2. No private investors should advance money in the capacity of stockholders or owners. Initial working capital may be provided by individuals, hospitals, chests, councils or other civic agencies, but should be repayable only out of earned income, over and above operating expenses, payments to participating hospitals and legal reserve. No organizations or individuals advancing initial capital should attempt to influence or direct the management of hospital service plans because of their financial support. The hospital service plan should be independent of any other corporate body or professional or lay group.

3. Plans should be established only where the needs of a community are not adequately served by existing nonprofit hospital service plans. Opportunity should be given for all institutions of standing in each community to become member hospitals in a hospital service plan and subscribers should have free choice of hospital at the time of sickness or accidental injury.



Type of publicity photograph used by the Plan for Hospital Care, Chicago.

4. The hospital service benefits of a nonprofit hospital service plan should be guaranteed by the member hospitals during the life of the subscriber-contract. The ultimate economic responsibility for service to subscribers enrolled at any given time should be assumed by the member hospitals, through definite contractual agreements with the hospital service plan. All contracts involving the plan, the subscribers and the member hospitals should be equitable and consistent with respect to the rights and obligations of each party.

Benefits in member hospitals should be expressed in "service contracts" that describe specifically the types and amounts of hospital services to which the subscribers are entitled.

A majority of the hospitals of standing should be member hospitals in each area in which a hospital service association enrolls subscribers, and arrangements should be made for provision of service in nonmember hospitals.

In case of physical impossibility to provide service in member hospitals

or others, equitable arrangements should be made for protection of the subscribers' interests.

It is understood that state legislation may require modifications of these requirements.

5. Subscription payments or dues received should be currently separated into earned and unearned income. The earned income should be apportioned to special accounts each earmarked for special purposes, as follows:

Hospitalization: For payments to participating hospitals. Charges against this account should include estimated payments for undischarged cases (desirably 60 to 80 per cent).

Contingency Reserve: In minimum ratios determined by law or in larger proportions designated by action of board of trustees (desirably from 5 to 10 per cent).

Field Service and Administration Expense (not exceeding 15 to 30 per cent): The cumulative ratio of field service and administration expense to earned subscription payments or dues should not exceed 30 per cent for the first full year, and the monthly ratio should be considerably less by the end of the year. Ultimately the ratio should not exceed 15 per cent.

In the calculation of earned income from subscription payments or dues during a given fiscal period, only those cash receipts should be considered earned that apply to and are intended for the payment of hospital benefits and expenses during that period. When subscription payments or dues are received in advance of the fiscal period to which they apply, the unearned portion should be accurately determined and separately recorded in the accounting records.

The formulas for calculating unearned subscriptions established by the various state departments of insurance are, in general, acceptable to the commission. Where a nonprofit service plan is not supervised by the state department of insurance, the uniform procedure adopted by the council on hospital service plans is

recommended. Details of this procedure can be obtained from the commission on hospital service.

6. Statistics should be maintained currently as follows: (a) number of subscribers (classified); (b) number of hospital admissions (classified); (c) number of patient days of care (classified), and (d) number of member-months (or member-years) of protection to subscribers (classified).

7. Initial working capital should be sufficient to carry all acquisition costs and operating expenses for a stated period (e.g. six months) after contracts first become effective, thus making earned income from subscriptions available in full for payments to hospitals during this period. Financial statements of operations and condition should be prepared by certified public accountants at regular intervals, at least annually.

8. Approval by the commission on hospital service requires the following minimum conditions: (a) a substantial number of enrolled subscribers having in mind the possibilities of the area served; (b) an experimental period of successful operation, usually not less than six months of enrollment activities; (c) an earned operating surplus, with admissible assets in excess of all liabilities (including unearned subscription payments or dues) and contributed capital. The same requirements apply for annual reapproval by the commission.

9. Payments to hospitals should be based on the costs of services provided to subscribers in hospitals of that community, district or region. This does not preclude the possibility of developing public ward service plans for employed groups with low incomes and agreements by member hospitals to provide service at rates less than the full operating costs.

10. Employees of a nonprofit hospital service plan should be reimbursed by salary as opposed to a commission basis. A private sales organization should not be given responsibility for promotion or administration on the basis of a percentage of premiums. Promotion and administrative policies should be dignified in nature, consistent with the professional ideals of the hospitals concerned and in accord with econom-

ically sound practices as determined by actuarial and financial experience of the various plans.

11. In communities with only one hospital, the finances of a hospital service plan should be separate from the general budget of the hospital.

12. Hospital service provided through a hospital service plan should be determined by the practices of the

member hospitals of the particular plan.

13. Hospital service plans should not interfere with existing relationships between physician and hospitals or between physicians and patients.

14. A hospital service plan should meet with the general approval of the commission on hospital service of the American Hospital Association.

How Much Dental Service?

IN THE survey made of the hospitals in the United States by the committee on hospital dental service of the American College of Dentists, it was decided that the dental service offered must vary according to the type of medical service offered and the ability of the hospital to establish and to maintain a dental department.

It was determined that complete dental service should be provided by federal hospitals, state welfare hospitals, sanatoriums, various specialty hospitals, orphanages and children's hospitals. County and municipal hospitals, private, semiprivate, endowed and fraternal hospitals offering general medical care should provide general dental service.

In university hospitals (teaching institutions) dental operations of an emergency character only should be offered in addition to the necessary oral surgery procedures. Contagious disease hospitals and institutions for the treatment of cancer should provide a limited dental service. In institutions dealing with cancer, dental staff members should be capable of making radium applications and fixation appliances and should be able to carry out proper procedures in the treatment of such conditions within the oral cavity. In eye, ear, nose and throat hospitals, in which the service consists primarily of the eradication of oral foci of infection, the need of complete dental care is questioned.

All hospitals should be equipped to provide adequate mouth hygiene before the administration of a general anesthetic.

Among the excellent recommenda-

tions made by the committee on hospital dental service were:

1. Only dentists of merit and members of the American Dental Association should be appointed to the dental staffs of class A hospitals. The American Dental Association should have authentic and unbiased information on its members on record for hospitals seeking competent dental staff members.

2. Student nurses should be given a course in oral pathology and oral hygiene, and the dental staff should provide them with periodic dental examination and prophylaxis.

3. It is advisable that dental radiographs be made by the dental department.

4. Dental students should be allowed to make weekly ward walks and should be allowed to assist in oral operations when conditions are favorable.

5. It would be advantageous if a course in oral pathology and gross dental diagnosis was given to hospital interns and residents.

6. Dental research should be encouraged in dental departments.

7. Proper officials of the American Medical Association, the American College of Surgeons and the American Hospital Association should be approached when cooperation and assistance are sought in the establishment of dental departments in hospitals.

8. It was recommended that next year's committee on hospital dental service prepare a plan for minimum standards of hospital dental service, to be used as a model for hospitals establishing a dental department.—DAVID TANCHESTER, D.D.S.

What I Expect From My Board

E. M. BLUESTONE, M.D.

MY RIGHT to expect anything from my board of trustees derives from the fact that I was engaged by it in the first place. I am not sure that the medical men of the hospital were consulted but, if they were, they apparently gave their approval. Those who were to be my chief concern—the patients—were not consulted in my selection. While I must admit that this gives me food for thought, I must say at once that I feel as deep a sense of responsibility to them as if they were my masters. The first thing that I expect from our board of trustees, therefore, is an appreciation of my interest in the comfort of the patients who have been entrusted to its care.

The board of trustees and I have pledged our faith to each other. It is by the grace of that supreme executive, legislative and judicial body that I hold the mandate of my office. Since the trustees are thus omnipotent, I expect that sufficient power will be conferred upon me to parallel the authority that goes with my position. They are my superior officers and I am directly responsible to them. Having undertaken the task of carrying out their wishes in the hospital, it goes without saying that my appointment indicated from the start that, in a general way, I was in harmony with their policies. I must confess, however, that I accepted the appointment with a mental reservation, even though I was fundamentally in agreement with my future employers. I expected, though this was not stipulated in the bond, that they would submit to an educational process that would naturally result from the engagement of a hospital administrator who, in their opinion, had some expertness in his specialty.

Doctor Bluestone is administrator of the Montefiore Hospital, New York.

I must add, at this point, that I have no contract with my board. "The letter of the law killeth. . . ."

The flow of authority in the hospital, as I see it, is as simple as these words indicate, though this is not yet fully understood by those who must submit to authority from time to time. I expect the governing authorities to be aware of this psychological situation and to do whatever they can to improve it. "Passing the buck" to the board is a perfectly legitimate phenomenon when indicated by special occurrences.

I have said that the board is the final authority in the hospital. The

Next month a lay administrator will express his views on the same topic

commanding position that it occupies arises from an interesting social development. The strong members of the community, in response to an instinctive feeling of mutual aid, banded together for the protection of its weak members. Hospitals were eventually organized and the representative strong members of the community, responsible men possessing qualities of leadership and knowing the value of discipline in organizing for the care of the sick, developed what we now call a board of trustees.

Membership on the governing board of a hospital is a sacred trust and every good trustee must surely find his reward some day. It is a rare opportunity to be a hospital trustee and one that I could wish for my best friends. If I had a son who could achieve hospital trusteeship I should die happy in the thought that he had lived a useful and noble life

of service to his fellow men and proved himself worthy. My superior officers are, therefore, trustees of a vital social activity. I am aware of their privileged position and expect them never to forget it.

I expect my board to exercise the greatest care in selecting its executive officers and also in selecting new trustees, with all of whom I am expected to work in such a humanitarian enterprise. I expect my board to know whence it comes and whither it goeth. I happen to be going the same way and, therefore, feel a sense of kinship with them. I have often told my superior officers that I consider myself a trustee of the hospital as well as its administrator. If my board appreciates its aristocratic position in the world of charity, I can be content with the feeling that my work as administrator will bear fruit.

I expect a human relationship with my board of trustees. We must understand each other and approve each other's motives, methods and purpose in life, either immediately or after frank discussion. We must speak the same language, think the same thoughts and plan the same deeds, all for the sake of our patients, no matter how we may differ politically or in any other way not directly concerned with the care of the patient. I must have the board's technical assistance from time to time and expect it to be granted to me freely.

I should, indeed, feel that my time had come if a major difference of opinion, which could not be reconciled, had arisen through a fault on either side that was not subject to correction; or, if many small differences of opinion making for an unharmonious relationship and reflecting unfavorably on the care of the patients, showed no signs of change after a time.

Philanthropy, in the financial sense of the word, depends upon the capitalist system for its survival and so does the voluntary hospital. Whether philanthropy is more genuine or more humanitarian under a different economic system and whether the voluntary hospital has merits that cannot be achieved under any other system are questions that do not enter into the administrator-trustee relationship.

There is doubtless much to be said on both sides, but technical hospital administration, in any case, requires a governing body that (a) knows how to plan wisely; (b) gives the administrator's initiative full play; (c) sees to it that the budget is balanced; (d) is willing and able to attend board and committee meetings and render highly specialized assistance from time to time; (e) upholds the discipline of the hospital, and (f) is in all other ways aware of its responsibilities.

If any political differences of opinion exist they must not be permitted to affect a relationship which, in the final analysis, depends on the sick poor for its existence. This subject should be studiously avoided and neither side should involve the hospital in such disputes.

Expects Rigid Impartiality

I can hardly believe that any material consideration would influence our mutual obligations to each other and to our patients. Only if I felt that the essentially humanitarian quality of hospital service had been deliberately injured by those who employed me would I part company with them. I expect my board to know that I, too, have a strong sense of responsibility. Apart from such a forbidding contingency, if I were to find that I could be more useful in another field of activity I would make my departure as little of a hardship on our patients as possible, just as I would expect that, if the situation were reversed, my board of trustees would deal as fairly with me (and then proceed to look for a better administrator).

I keep my board closely informed and present every problem as fairly and as completely as I can and expect it to ask among the first questions, "What is best for the patient?"

before letting me have its decision. I expect my board to be rigidly impartial at all times. There must be no trace of favoritism in any phase of hospital activity in which the sick are concerned. Complete and absolute freedom from bias must prevail in every activity of the hospital, whether patient, relative or employee is involved. I expect my board to see to this by setting the example.

Budget Balancing Hardest

It seems to me that the executive, legislative and judicial functions of my board are the easiest for men of their caliber to perform. It is the balancing of the budget that makes their task so difficult. I expect my board to appreciate its responsibilities in such a situation to the extent that it will remove from my mind, as much as possible, the burden of worry over the financial deficiencies of hospital life. This kind of restraint has a deadening effect and I expect my board to realize it. The hospital being a communal institution, combining a social with a scientific purpose, I expect a progressive attitude to prevail among the board members at all times, in prosperity and in adversity.

I realize that executive duties have been delegated to me while the board retains the power to decide appeals from my decisions. On this point an understanding should exist. I expect a reasonable amount of support in carrying out my duties as they have been assigned to me. Policies must be set, rules and regulations must be promulgated. If the administrator is the expert in administrative medicine that he was taken to be in the hour of his appointment, his advice should be sought when changes of any kind are indicated.

Since the duty of discipline is his and he must see that the policies of the hospital and its rules and regulations are observed, he has a right to expect support. As representative of the board of trustees in the hospital, he must see that the peace is kept and that the patient is getting the most out of his stay, failing which he must recommend modifications to the board as the occasion requires. No board of trustees can proceed independently in vital matters affecting the hospital and expect

the administrator to be happy in his work if he is not taken into its confidence.

I know that the board cannot substitute for me in my efforts to command the respect of patients and employees since this is inherent in my personality, character and training, but my board can do much to convince everyone concerned that I am the executive and that my influence in the hospital is a wholesome one. If the trustees and their opinions are worthy, no better combination for progress can be imagined. The trustee serves his patients best and most unselfishly who knows how to cooperate with the administrator (while guiding him with the advice that comes from maturity), who displays a deep concern for the underprivileged in the hospital and who brings a wealth of experience in other fields of endeavor that has special value in hospital administration.

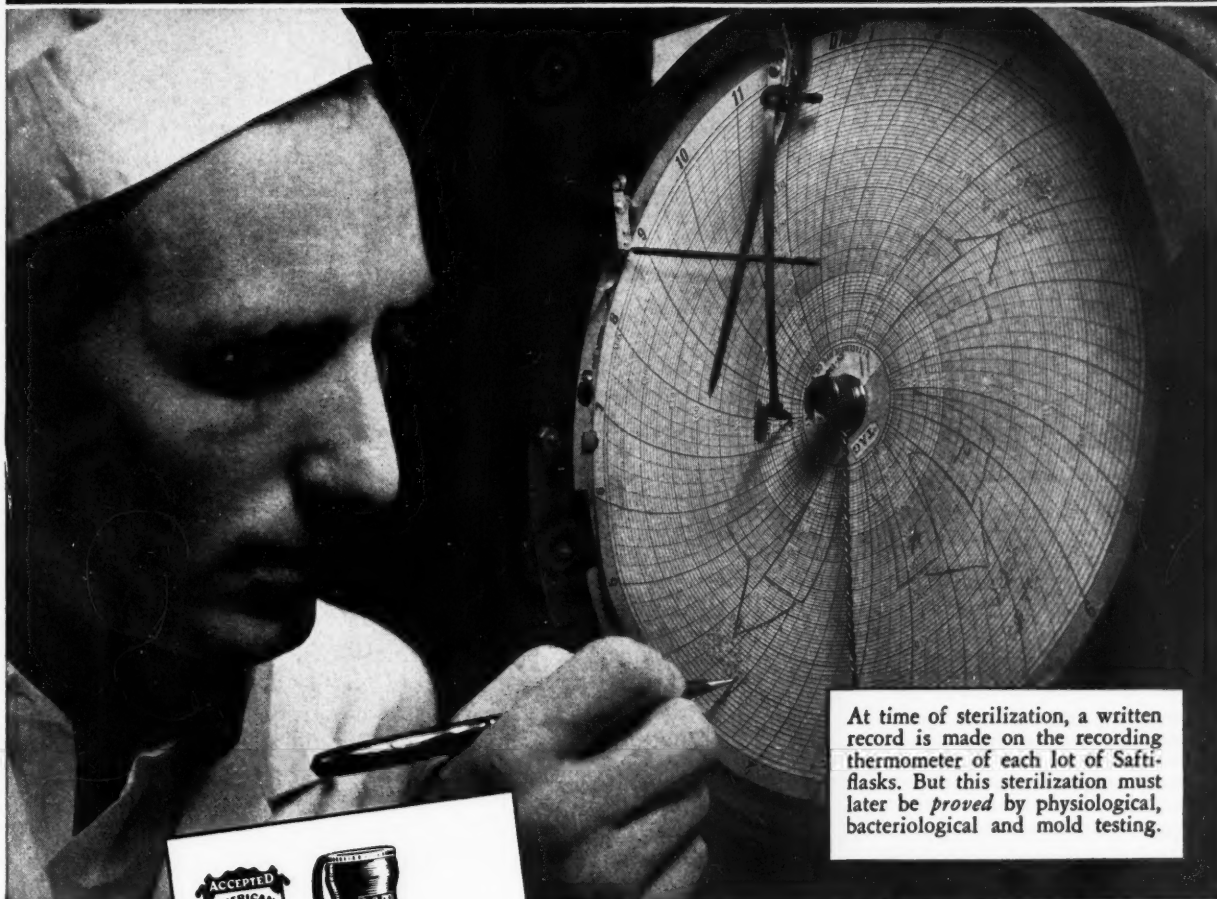
I expect my board of trustees to be a court of appeals that recognizes that I am only human and, therefore, fallible; a legislative body that knows where to go for sound hospital advice; a firm executive force where the interests of the patients are concerned, and a financial corporation in which each member is able and willing to play a leading rôle.

Must Know What Not to Do

The character of the trustee is a measure of the quality of the hospital. The administrator has a right to complain when character, understanding, interest, cooperation, generosity and sympathy are lacking. The tendency to "let the administrator do it," and to stand by inactive, must be discouraged. I expect the trustee to be open minded, cultured and humane. As a rule, he is the pick of the upper strata of the community. He must be big enough to step down occasionally and to learn the technics of hospital service from the administrator and from such other instructors in the hospital field as the administrator may from time to time prescribe for him. The good trustee receives while contributing and it is in this respect that I find one of my greatest opportunities with the splendid men who happen to sit on my board.

On the negative side there is some-

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thing more to expect. I want my trustees to know what not to do. Many of my colleagues dread the interference of trustees in the routine administration of the hospital. This interference is generally conceded to be the greatest single threat to the authority of the administrator. A discussion at this point with a newly elected trustee is the first step in his education for hospital service, unless he arrives with a full understanding of the situation. The negative type of trustee requires neutralization through diplomatic channels.

The upper millstone, consisting of the governing board, and the lower millstone, consisting of the working staff, must grind out the finest product that can contribute to the health of the community. The administrator must never allow himself, or be

permitted, to be caught between these two forces. It is for him to see that the interaction between these two parts is as perfect as human beings can make it, but he must have safeguards to protect him from injury in handling such delicate yet cumbersome machinery.

Collaborating with such a board as I have described, any administrator may carry on with a feeling of safety. He need not be uneasy about the conditions of his employment, including the tenure of his office, which is the greatest single worry to any qualified man whose lot may be cast with a board that has not been educated to its essential task. I give the best that is in me and expect appreciation for my efforts in the form of pleasant and cooperative relationships at all times.

provide the hospital theater with all essential properties and take care of the box office deficits resulting from free admissions. — *Presbyterian Hospital, Chicago.*

Nurses' Health

- The health of the nursing staff is something that requires constant attention. A half-well person is no asset to an institution. Our students are admitted with a clear bill of health from their family physician, a negative chest x-ray and immunization against typhoid fever.

Immediately after admission to the school they are reexamined and x-rayed to make doubly sure of their physical fitness. They are tested for susceptibility to diphtheria and susceptible ones are immunized. A Mantoux test (for tuberculosis) is done. When admitted, a very small percentage show a positive reaction. The negative ones are retested every three months and those who have become positive are reexamined and have a chest x-ray. All students have a chest x-ray every six months in an effort to detect tuberculosis early.

Nurses with colds and sore throats must be removed from duty on account of the danger of infecting the patients. This is one of the factors that make it difficult to maintain a stable nursing service. In other occupations these individuals would be able to remain at work. Here it is obviously unfair to patients.—*FANNY MUNROE, superintendent of nurses, Royal Victoria Hospital, Montreal.*

Medical Insurance

- Perhaps the most important feature of the nonprofit plan to be operated by 16,000 physicians in 17 counties in southern New York State to insure an individual against \$150 to \$300 in annual doctors' bills for \$12 to \$24 a year is that the subscriber will be allowed to select his own physician. . . . The corporation would provide subscribers with insurance covering doctors' bills just as the hospital associations provide insurance against hospital expenses. . . . An individual, by paying \$1 or \$2 a month, will become entitled to a credit perhaps of \$150 to \$300 a year for his doctor's bills.

In other words, by paying about \$10 a year for his voluntary hospital insurance and \$12 for medical indemnity insurance he will, in most cases, be insured against the cost of his medical and hospital care.—*J. DONALD WHELEHAN, deputy superintendent of insurance, New York.*

WHAT THEY ARE SAYING

National Health Bill

- When this bill became available for our study, we found much of good in it, but to our extreme regret and to our great anxiety for the future of what is already the world's best hospitalization coverage of a nation, we found that much of our advice and most of our warnings to the Interdepartmental Committee had, apparently, gone unheeded. May I emphasize that the hospital profession of this country is socially minded, that we know that problems of securing adequate hospital care do exist. We do not hide our heads in the sand and say, "I see no need, therefore there is none." But, also, our association is composed of the elements which have pioneered hospitalization in America and, to the informed, it is obvious that what is thus far known about hospitalization of the sick and injured is at our fingertips. We are accustomed to think in terms of community values, not in terms of selfish considerations. Our advice should be heeded.—*CLAUDE W. MUNGER, M.D., past president, American Hospital Association, in statement to Senate Committee on Education and Labor.*

- I believe the Wagner bill can be changed suitably either by amendment or substitution. . . . I believe there should be a single federal health authority whether it be an independent agency or a department of Cabinet

rank.—*EDWARD S. GODFREY JR., M.D., president-elect, American Public Health Association.*

- If the President can show me a single self-liquidating hospital in these United States, he will get my vote for a third term. . . . I attribute my premature old age in part to my service on hospital boards and the struggle to meet the deficits.—*BRUCE BARTON, representative in Congress, New York.*

- One provision of the Wagner health bill would make hospital funds available only for buildings to be owned by states or political subdivisions. . . . This provision might destroy many existing church hospitals, community general hospitals and other hospitals which have given the best hospital service in the world.—*R. L. SENSENICH, M.D., South Bend, Ind., trustee, American Medical Association.*

Wanted: A Supporting Cast

- Rarely do headlines and radio newscasters tell of the dramatic life saving that is a part of the day's work in the hospital. No medals are awarded to those whose quick thinking and ceaseless vigil win uncounted victories over death day after day and year after year. Nor do the principals in the hospital's life-saving drama want headlines or medals. All they want is a "supporting cast" whose loyalty and generosity will



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our patients use in their
homes..thin safedge glasses"**

Diet authorities agree that hospital meals should be pleasantly homelike in every detail. That's why leading hospitals use thin-blown Libbey Safedge Glasses. They are appetizing to drink from and easy to hold.

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Before You Pay the "Piper"



Properly planned layouts are essential to satisfactory piping systems, but proper layouts alone do not ensure an adequate job. Good workmanship is a foremost requirement.

R. STARR PARKER, M.E.

lead, tin, zinc, brass, rubber, cement, glass, phenolithic plastics, asbestos and tile, as well as coated and plated pipes of all descriptions. Each material has a specific application for which it is unexcelled. In many cases a material that would be a miserable failure in some application would be ideal for a different set of conditions. Hence, a knowledge of the proper application of piping materials must be accompanied by an equally sound knowledge of the material's limitations.

The selection of the proper materials for a given installation is only the beginning of a satisfactory installation. The run of the system, main headers and branch lines, all must be properly planned to ensure a well-balanced layout, one that will not be oversized in some sections and undersized in others. Although oversized piping provides for expansion of facilities at no additional installation cost and has marked advantages in reducing pumping friction loss, nevertheless, it represents an economic waste if its possibilities are never utilized. Properly planned layouts, then, are essential to the best piping systems.

However, proper layouts alone will not ensure an adequate job. Haphazard workmanship can ruin the best planned piping job. Because much of the piping in a hospital is concealed either in pipe shafts or in false ceilings it is imperative that the installation be made in the most workmanlike manner possible. All possibility of leaks resulting from assembly must be minimized, even in the laundry or power house or areas where the piping is in the open; a leak usually requires a certain amount of expense for repair.

CONSIDERING the miles and miles of piping that are installed throughout a hospital, the subject of proper piping should be of primary importance to everyone engaged in the design, construction, supervision or maintenance of any institution. Modern hospital construction demands that serious consideration be given to the design of the piping system if trouble-free service is to be expected from the myriad lines that distribute the various liquids and gases throughout the hospital plant.

It has been said that a hospital eventually pays for a good piping installation, whether or not it gets it in the beginning, in increased maintenance costs, in repairs and in damages occasioned by costly leaks. Un-

Mr. Parker is the mechanical director of Christ Hospital, Cincinnati.

fortunately, many engineers who give the original piping installation the proper thought and consideration disregard or neglect, as being too small a point to matter, any subsequent additions or changes to the piping layout. The piping problem, however, is always with us and is least apparent when the most attention has been given to the details of design, installation and maintenance.

Probably nothing short of fire can cause the havoc that a really first-class steam or water leak can cause, particularly if the lines happen to be concealed above an expensively decorated ceiling in an expensively furnished interior.

There are almost as many kinds of pipe as there are materials of construction; these include wrought iron, cast iron, steel, copper, stainless metal,

A Mattress Story that SPEAKS FOR ITSELF



WHAT IS *Airfoam*?

Airfoam is made by beating pure latex into an airy foam which is molded into any shape and cured by a patented process that insures long life. Do not confuse it with so-called "sponge rubber." *Airfoam* is an odorless cellular latex product made only by Goodyear.



RECENTLY a famous general hospital in a large eastern city purchased an **Airfoam** mattress for test purposes. At first it was placed in general service, but patients commented so favorably upon its unusual comfort that it was transferred to the emergency ward for receiving certain types of severe accident cases. The hospital reports that particularly in the cases of back injuries the mattress provides great relief, and further comments that all hospitals should have at least one **Airfoam** mattress available for such emergency use.

We know no better proof of the exceptional comfort of this revolutionary new mattress, made by Goodyear from pure latex. Not only is it a boon to bed-weary patients, but its highly sanitary construction is a distinct advantage in hospital service. **Airfoam** is repellent to vermin, inhibitive to bacterial growth and can be easily sterilized or washed when necessary. It is dustless, odorless and retains its resilient life for years.

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One of the materials most commonly used in pipe construction is wrought iron. Everyone is familiar with the resistance to the elements of the wrought iron fences, grilles and exterior building ornamentation so much in vogue during the latter half of the last century. That same material, produced under constantly improved methods of metallurgic control, has been fabricated into pipe for many years and manufacturers claim marked superiority for this material in many classes of service.

It is claimed that wrought iron pipe can be adapted to nearly every class of service: steam, condensate and water lines; air and gas piping, and outside hand railing. One recent installation of a heating system called for the steam lines to be imbedded in the concrete floor so that there would be no possible chance of ever repairing leaks that might develop at some future date. Repairs will, in fact, be impossible on this job without tearing up the floor, but it is expected that the selection of wrought iron pipe for this service will preclude the necessity for future repairs. Such unusual applications should always carry the manufacturer's approval and should follow his recommended procedures.

Steel pipe has many justifiable applications, *i.e.* where strength, economy and low initial cost are desired

and where corrosion resistance is not a serious factor. Any fluid or gas in which corrosion, abrasion, rapid oxidation or alkaline or acid conditions are not serious factors may be suitably carried in steel piping. Steel pipe is well adapted for steam lines as well as for refrigerant piping and is obtainable in a wide variety of standard weights for service under pressures up to many hundreds of pounds per square inch. When steel is alloyed with molybdenum and chromium it can be fabricated into pipe that will safely carry steam at 1200 pounds' pressure and at 900 degrees F.

For ease of handling and fabrication, steel pipe probably has no peer. It is easily welded by both the acetylene and electric arc processes, methods that are coming into more common use. Either method is good and produces entirely satisfactory results if carried out by competent mechanics. Ease and economy in installation as well as in repair justify welded pipe; in addition, the problem of insulating against heat leakage is considerably simplified in a welded installation. Although even the smallest shops are usually equipped for cutting and threading pipe in smaller sizes, welding simplifies the installation to such a degree that in time most hospital piping will be installed by this method.

Steel pipe has a reasonable length of life when used for conveying both hot and cold water, either hard or soft, but it is quite important to make sure that the water has been treated, either electrically, chemically or by deaeration, to protect against dissolved gas corrosion. The gases present in all water are most active at the usual hot water temperatures.

Cast iron has been in use for years as an undisputed standard for sewage lines, both domestic and industrial. Although the material is brittle, costly to install, awkward to handle and has practically no elasticity, it is the one pipe that is usually in good shape when the building is torn down. Certain corrosive gases and liquids will attack it, of course, but none of those that are ordinarily found around a hospital. For drain lines and plumbing vents hospitals probably would not use anything else.

If the material had some flexibility it would probably have more extended application. As it is, cast iron is confined to atmospheric pressure work except in a few isolated instances. For example, a special alloyed cast iron is about the only material available from a cost point of view that will stand up under the combined high temperature and severe abrasion found in ash conveyor systems.

Copper pipe is an ideal solution to many piping problems, although there are decided pressure and temperature limitations to its use. Copper pipe can be obtained in standard pipe sizes and, in addition, is manufactured for low pressure work in the lighter weights of tubing sizes. In the past it has been the customary practice to fabricate copper piping in the same way that steel pipe was handled, namely, with threaded joints and fittings. However, in recent years a line of fittings, elbows, tees, unions, valves and couplings has been placed on the market that eliminates the necessity for threaded joint in copper pipe installation. These "solder fittings," when properly made up, are stronger at the joint than is the tubing itself and permit exceedingly rapid installation.

The fittings themselves are somewhat more expensive than standard threaded fittings, but the labor sav-



Roughing in for a battery of lavatories, Manteno State Hospital, Manteno, Ill.



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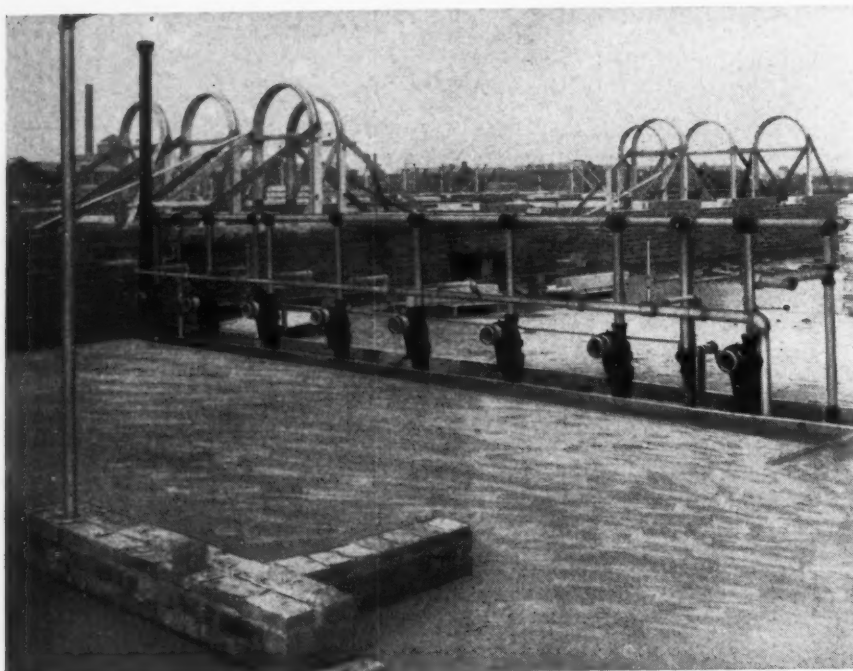
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Initial roughing in for a battery of toilets, also at Manteno State Hospital.

ing is appreciable and by judicious layout and the use of a pipe bender many fittings can be eliminated.

Vacuum return lines on the heating system, a particularly severe service in some instances, constitute an ideal application for copper pipe, particularly if those lines are installed under a concrete floor that has an expensive wood or composition surface.

Threadless copper fittings really streamline the installation and present a smooth surface both inside and out comparable to an all-welded job. This material is seldom used on the pressure side of heating systems, where wrought iron and steel still predominate. At the moment, copper piping seems better adapted to plumbing installations, smaller water lines, gas lines and the like than does other material. Many public utility companies, in fact, have practically standardized on copper pipe and solder fittings for their residential services.

Brass pipe has much the same application as copper. However, there are localities in which public water purification systems so affect the water that it, in turn, affects the brass and some of the brass pipe installed has not lasted as long as would other materials under the same conditions. Dissolved gases combined with certain chemicals present in the water

seem to have an affinity for the zinc in the brass with consequent embrittlement of the piping. There is some difference in the quality of the brass pipe marketed, as indicated by the literature published by reputable manufacturers of this material. Brass pipe is generally semi-annealed (although that is a good point to check when buying) and comes, as a rule, in standard pipe sizes for use with standard cast brass or bronze screw thread fittings.

Copper and brass are not cures, of course, for line stoppage resulting from deposits from the water, nor can they improve poor workmanship in installation. No matter how good the materials may be a poor installation can still spoil the job.

The stainless metals are installed most often in the kitchen and dairy where ease of cleaning, positive resistance to corrosion of all types and general appearance are the prime requisites. Stainless metal has practically supplanted tin in all types of dairy piping and in kitchen containers.

Rubber lined pipe is available for abrasive service and stands up well under such conditions. Acid conditions in which temperatures are kept low are another fertile field for rubber pipe installations.

For exterior architectural services, such as downspouting and ventilat-

ing ducts and stacks, copper bearing steel is recommended because of its higher resistance to external atmospheres and weak acids. It is a generally accepted belief among metallurgical engineers that the addition of even small amounts of copper to steel will prolong the life of that steel under adverse conditions.

Hard-pressed asbestos materials make excellent ducts for corrosive fumes or installations in which weather resistance is a factor. Asbestos pipe can be purchased for a number of specific uses in unusual applications.

The corrosive acids that are frequently discharged from certain hospital departments, especially the laboratories, put a severe test upon any pipe that is subject to deterioration from such acids. Special pipe made of high-silicon iron or of acidproof tile is found useful in these situations. These types are said to outlast the life of the building without regard to the quantity or character of the acids to which they are subjected.

Lead pipe, for years the standard for underground service, required no protective covering against the chemical action of the soil or even conduit for mechanical protection and was probably the cheapest material available from a purely economic point of view. Other materials and methods, however, have in the past few years gradually replaced lead lines except in isolated instances.

The problem of conveying materials underground is one of considerable magnitude. There are several materials available for this service and a number of methods of installation that will give uniformly satisfactory results. The problem, however, is one that cannot be treated lightly. To begin with, the excavation cost is a large part of the installation cost, which necessitates the use of methods that will eliminate the expense of digging up the line for repairs. Copper and brass, as has been mentioned, are coming into extensive use for more permanent, higher class underground work. As with lead lines, copper may be laid directly in the ground with no additional mechanical protection provided, of course, there is no heat loss to guard against.

Steam pipes for underground serv-

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ice can be of steel or wrought iron if they are properly protected with an absolutely water-tight covering and if the covering is protected against breaks. Ground moisture containing a high percentage of dissolved acids or alkalis can spoil money-saving insulation in a comparatively short time and can cause costly leaks that may not be apparent for many months.

A conduit system is available that is particularly suitable for more extensive installations. The system consists of units that combine either single pipes or groups of pipes in all sizes up to 14 inches, packed in moisture repellent asbestos insulation and encased in a water-tight glazed conduit. The pipe rests on steel rollers built into the conduit and the whole is supported by a continuous base drain made of vitrified glazed tile.

The company that makes this system makes a presealed insulated pipe unit in which the insulated pipes are hermetically sealed with spirally corrugated, galvanized iron covering. The units are supplied in any lengths desired (or in standard 20 foot sections) with all accessories ready for field welding and with a heavy bituminous coating applied to the exterior of the casing.

Waterproofing Pipe and Cover

One satisfactory method of burying steel steam lines consists of wrapping the insulated line with a covering of waterproof roofing paper laid on in hot asphalt and given a mopping of hot asphalt after wrapping. The line is then enclosed in a vitrified tile conduit laid on a bed of gravel. Under no conditions should an asbestos or magnesia covered line be laid directly in the ground without waterproofing nor should an iron or steel line be laid in a cinder fill without doubly protecting it against moisture reaching the steel. The sulphur in the cinders is extremely corrosive and, dissolved in the ground moisture, will eat out the line in short order.

One particularly fast and satisfactory method of waterproofing both pipe and covering is to wrap it with a special tape similar to electricians' friction tape but manufactured in wider widths and made especially for moisture-proofing pipe. It goes without saying, of course, that some sort of mechanical protection is still



Underground installation for the Veterans Administration Hospital, North Chicago, Ill. The conduit system is particularly suitable for the more extensive installations.

required to protect against mechanical abrasion.

No article on piping would be complete without at least a brief mention of pipe covering in general. There are two fundamental reasons for covering: (1) to prevent heat leakage, which means heat loss from steam lines and heat leakage into refrigerant lines, and (2) to protect the lines against exterior deterioration.

Standard coverings are made of such materials as air cell, paper, asbestos and magnesia for steam, and cork and hair felt for refrigerants. Purely protective coverings may take almost any form. Excellent guides are available for the selection of the most economical covering for a given set of conditions and have been proved trustworthy through laboratory experiment and by use in the field.

Some controversy exists as to the value of painting both covered and bare pipe lines when conditions of service do not demand it. It is my contention, however, that painting is more than justified. Furthermore, the lines should be painted different colors to indicate their contents. Such a scheme will reduce a maze of pipe lines to a simple well-ordered layout. Not only does a pipe painting schedule make for rapid identification of the lines but it might, in an

emergency, save serious error. Excellent guides have been set up by the American Society of Mechanical Engineers in its "Color Scheme for Piping," which may be obtained at a nominal cost from headquarters at 29 West Thirty-Ninth Street, New York.

Finally, a good installation is always dependent upon first-class workmanship. A good installation would dictate careful adherence to the following considerations, which someone has called the 10 commandments of a master fitter: (1) accurately cut threads; (2) reamed pipe ends; (3) proper joints with tight fits made up with proper thread lubricants; (4) lines leveled and plumbed without strain, and pitched as required; (5) sufficient supports; (6) proper allowance for expansion; (7) trenches and tunnels properly drained and vented; (8) tight insulation properly protected; (9) immediate attention to minor leaks, and (10) avoidance of the use of acid cleaners.

Duplicating Processes

There are two common methods of obtaining hectograph copies. They produce copies economically in several colors, usually purple.

By the older and better known method a typed or drawn copy is transferred from the master to the copy, using a "bed" of gelatine as a medium.

The second or so-called liquid method eliminates the gelatine and prints directly from master to copy.

The advantages of the latter type are: (1) more copies; (2) faster operating cycle (less time between preparation of master and actual production of copies); (3) no messy water or gelatine to touch, and (4) possible reuse of the master copy. The master may be used and then filed. Should a need develop, additional copies may be made with no extra preparation.

This last advantage is the most important. There are dozens of times when a form is rewritten exactly the same. A form may be prepared part way and then copies may be made again of the entire information. This can be employed for admitting, surgical slatings and many other uses.—RONALD YAW, *Blodgett Memorial Hospital, Grand Rapids, Mich.*



For SPIRIT LAMPS TOO...

For Therapeutic Nerve Block or Spirit Lamps, U. S. I. Alcohol Is the Choice

While spirit lamps require only limited quantities of ethyl alcohol, it is especially significant when leading hospitals throughout the country use U.S.I. alcohol for this purpose.

Doctors know it is safe to specify U.S.I. alcohol exclusively for every hospital use. In therapeutic nerve block, for example, they have confidence in its freedom from toxic impurities that might injure delicate nerve bundles.

Because every shipment is checked for acidity that would exert corrosive action against bright shiny steel, U.S.I. is the alcohol preferred by most hospitals for sterilizing and prolonging the life of costly surgical instruments.

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tests for odor, proof, toxic impurities such as fusel oil constituents, aldehydes, and other organic matter, are a constant check on alcohol quality.

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60 EAST 42ND ST., N. Y. **U.S.I.** BRANCHES IN ALL PRINCIPAL CITIES

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Meetings Build Morale

FREDA GOLLOMBEK

THE housekeeper of a large general hospital is constantly confronted by many problems relating to the duties of the personnel in her department. To attempt to consider these problems directly with each individual employe is an almost impossible task and other methods of meeting the situation must be explored.

In the Jewish Hospital of Brooklyn, N. Y., it was generally agreed that periodic meetings of all employes at stated times would furnish a proper vehicle for coordinating housekeeping activities and for the establishment of uniform methods of carrying out the working assignment of the 80 members of the housekeeping staff. One of the principal reasons for adopting this procedure was the conservation of time for everyone in the department.

Agenda Well Planned

Since the meetings were first started more than a year ago our experiences have been most gratifying. The meetings are held, as a rule, on the first Wednesday of each month for half an hour before dinner. On occasions, and for sound reasons, it has been necessary to postpone the meeting for a week but in no instance has a meeting been postponed for a longer period.

Well-planned agenda of about six topics, never more than eight, dealing with problems that have arisen during the interval since the last meeting are prepared in advance. The topics are fully discussed by everyone who has anything to contribute to the subject and employes are urged to express their views.

The following list of topics will illustrate the character of the subjects discussed.

The author is housekeeper at Jewish Hospital, Brooklyn, N. Y.

1. Recognition of meritorious services by employes.

2. Advantages and disadvantages of cleansing products.

3. Care, use and storage of new and old articles of equipment.

4. Control of waste of supplies, such as cleansing products, paper and linens.

5. Adoption of a uniform method of cleaning best suited to the needs of the hospital.

6. Complaints from all sources about departmental activities. (All complaints are made the property of the employes as well as of the administration.)

7. Removal of stains.

8. Importance of eliminating undesirable and irregular cleaning habits.

9. Solicitation of criticism of cleaning supplies and equipment.

10. Demonstration by employes of improved methods of cleaning with helpful hints for short cuts.

11. Reports of sick members of the department to whom cards are sent in the names of their fellow employes.

12. Review of accidents to employes and the importance of a safety-first program.

13. Fire drills and the importance of being familiar with the rules for fighting fire and panic.

14. Importance of cooperating with employes of other departments.

15. Courtesy as an outstanding factor in the public relations' policy of the hospital.

16. Explanation of hospital rules governing holidays, sick leave, health clinic and hospitalization.

While she is making the rounds of the hospital, the alert housekeeper will observe incidents that concern all her employes, particularly if she finds more than two or them performing their duty in a manner that

merits disapproval. Such incidents, together with suggestions by employes, may constitute the major source of topics during a meeting.

Guest speakers from other departments of the hospital may be invited to address the employes. In our own hospital, the assistant superintendent of nurses, the assistant administrator and the purchasing agent have presented interesting talks on the relationship of their special interests to the housekeeping service of the hospital.

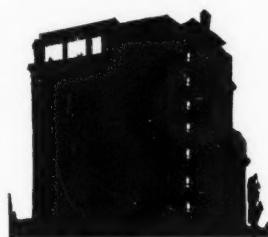
It has been found worth while to keep minutes of the meetings available so that even those who are off duty and excused from attending the meetings cannot plead ignorance of what has occurred.

Relationships Now Pleasant

It is our belief that sufficient time has passed to permit us to evaluate the results of these meetings. In general, we have noticed a marked improvement in the cooperative attitude of the personnel. Uniform practices have been introduced, in many instances following suggestions by employes, and the work assignments are more equitable. All complaints with reference to personnel practices are brought into the open for discussion in an atmosphere that is both friendly and fair. The practice of praising individual employes for efficient services in the presence of their fellow workers has stimulated a spirit of friendly competition among them.

The group has accepted criticism well and it has been noted that fault-finding and recommendations for improvement made in an open meeting appear to have more far-reaching results. The personnel, eager to work well and in harmony with others, is not under tension or pressure and is happy in the knowledge that relationships within the department are pleasant and that individual problems are not subordinated to the other activities of the department.

*Power lines went dead
thirteen times in a year*



... but this hospital never lacked light

FOLLOWING installation of an Exide Emergency Lighting System, the chief electrician in this hospital kept an accurate record of the electric current failures experienced. Over a period of approximately a year thirteen failures were recorded. In each instance, the records show that the Exide System functioned perfectly.

Exide Emergency Lighting insures adequate protection . . . which means both *automatic* and *instantaneous* operation upon any failure of the normal electric current supply. It's the first sixty seconds that count. The utility companies take every precaution, but cannot control the effects of storms, floods, fires, or street accidents. Privately-owned plants, no matter how carefully planned and operated, may also have interruptions that make Exide protection essential.

In addition to Exide Systems for large institutions, there is an Exide unit especially designed for the needs of the smaller hospital. The only care an Exide System needs is the addition of water four times a year. Write us for free bulletin.

THE ELECTRIC STORAGE BATTERY CO., Philadelphia
The World's Largest Manufacturers of Storage Batteries for Every Purpose
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SYSTEMS

The Maid and the Patient

MARY BLOUNT ANDERSON

OFTEN the first impression of the patient or his relatives upon entering a hospital room is that of cleanliness and order. These attributes are reflected in every detail of a properly kept room, whether occupied or unoccupied.

To procure the most desirable type of employe for this unit of hospital service, much care is required in selection and training; helpful supervision and proper encouragement must follow.

The hospital maid not only must be physically able and competent to do the required cleaning but also must be able to render this service in a manner pleasing to the patient and to those responsible for the professional care of the patient. A maid who is efficient and who is acceptable in her relations to patients needs the following qualifications: (1) health, (2) dexterity, (3) personality, (4) tact and (5) courtesy.

Sound health is a valuable asset to anyone; certainly the maid who is responsible for the cleanliness and orderliness of the patients' rooms must reflect physical fitness for her work and mental appreciation of the hospital environment and its significance. The patient may feel a bit of uplift when a maid comes into the room, does her work with quiet understanding and with deft movements and makes a speedy withdrawal.

Dexterity in handling her cleaning tools and materials is an asset to the maid and she, in turn, is an asset to the department. An ancient Chinese proverb says: "A poor workman quarrels with his tools." A well-trained maid handles her tools in a quiet and unobtrusive manner. She is careful to keep her mop and pail out of passageways. She keeps her dust cloths, cleaning materials and small utensils in a compact form in basket or pail and performs her clean-

ing duties with a sense of orderliness and with as little disturbance as possible.

The maid who presents herself in the morning neatly and comfortably dressed, rested and refreshed may be relied upon to start her day right, and a good beginning at her duties is most likely to have a good ending. The presence of a pleasant, competent maid on duty in the room may impart a sense of comfort and well-being to the patient and the relatives and friends of the patient. If a slight adjustment of shades or windows or an extra chair is desired,

Every possible precaution must be used to avoid unnecessary noise in or about the hospital. Use special care in handling cleaning equipment and in opening and closing doors. Make Quietness a habit, and in doing so you will contribute to the welfare of our patients and to the reputation of our hospital.—Footnote on the Work Schedule for Maids, Provident Hospital, Chicago.

the occupants of the room may make such a request without feeling that they are imposing upon an already fatigued worker.

Interest in the patient's comfort enables the maid to determine when it is necessary to vary the routine of her scheduled duties or her methods of cleaning. An example is the case of the patient who felt disturbed by the sound of running water from the faucet in the face bowl. The maid discovered this and, when cleaning the bowl in the patient's room, used water from a pail instead of the faucet; when cleaning the lavatory, she was careful to close the door. Later when the patient was recovering she expressed her appreciation of this thoughtfulness on the part of a very busy maid.

The tactful maid is careful of small details in the patient's room; the window shades are put at an even

height, the curtains are properly adjusted and other small adjustments are made which seem insignificant but which affect the physical and mental comfort of the ill.

It is essential that the maid recognize the importance of silence while on duty. A talkative person is often a bore to those in normal health and is a punishment to those who are ill.

The maid must be cautioned against discussing patients or personnel with other patients or employes. This should be the unpardonable error. If she runs into difficulties, as she sometimes does, she must report to the household supervisor for advice and direction.

Proper respect or regard toward those responsible for the professional care of the patient is an essential factor in the qualifications of a desirable maid. She must perform duties in harmony with the nurses and other attendants on the floor. She must make every effort to have her work well in hand and to have the rooms and wards in order by the time the physicians arrive. Although her work continues, she must be almost like a ghost, seen and unseen.

Finally, the maid has an essential part to play in the symphony of daily activity in the hospital; she must be in tune with the other players in order to get the results that can be had only through the harmonious endeavor of the entire personnel.

Cleaning Rubber Mattress

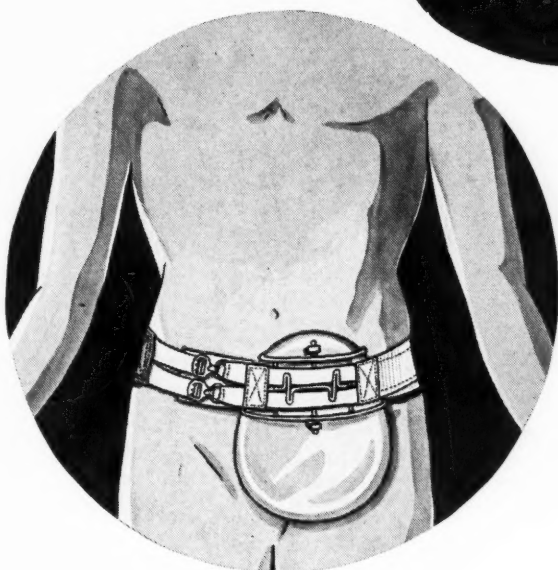
Increasing numbers of hospital housekeepers are attesting to the practicability and cleanliness of rubber mattresses. After two years or more of experimentation Mrs. Alta La Belle, Michael Reese Hospital, Chicago, tells how easy they are to keep clean. "We just douse them through soap suds," she explains, "with a very light disinfectant, and dry them out. Within twelve or twenty-four hours they are ready to be put back on the bed. We do not keep them in a ticking of any kind. We have only the normal bed sheet over them, no rubber draw sheets. There is very little deterioration or drying out at the ends."

Mrs. Anderson is household supervisor at Provident Hospital and Training School, Chicago.

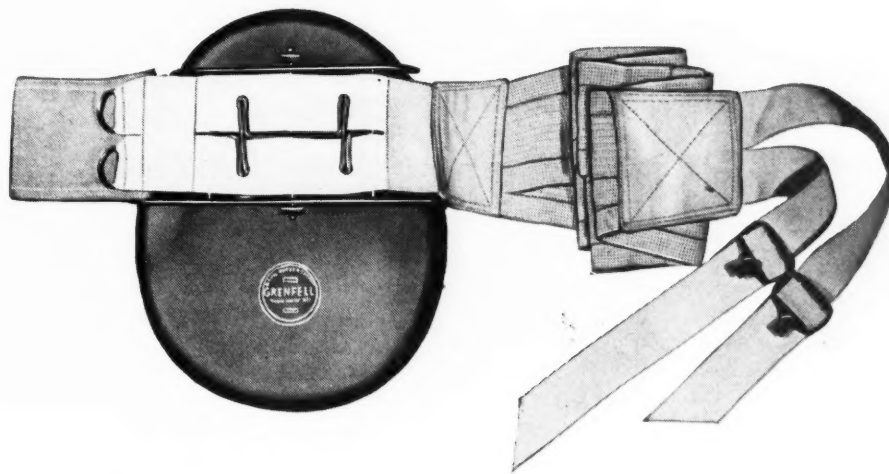
GRENFELL COLOSTOMY OUTFIT

by

DAVOL



Modern design; for use during day or night, in any posture. The complete Grenfell Colostomy Outfit consists of a translucent, seamless, amber-rubber pouch held in a light wire frame; elastic waistbelt; an additional rubber pouch for sanitary convenience.



SPECIFICATIONS: No. 1315 2½" opening
No. 1395 3½" opening

DAVOL RUBBER COMPANY, PROVIDENCE, RHODE ISLAND

Centralized Nourishment Unit

SOPHIA L. MORRIS

THE problem of sending supplies, such as oranges, lemons, eggs, cocoa and malted milk, to the various diet kitchens or floor pantries of a hospital has grown into a complex one that includes serving nourishments to patients.

We can recall in the early days carefully checking the order sheet of the charge nurse, especially noting the quantity of oranges ordered and wondering whether budgets would permit sending two or three oranges to each ward kitchen with perhaps a few more for a medical ward where we would expect to have diabetic patients. With a feeling of great extravagance a dozen oranges and six lemons were sent to the private floors. In those days it was considered good judgment on the part of a special nurse to ask her patient's family to bring in a dozen oranges or a few fresh eggs as such things

Miss Morris is director of nutrition, Newark Beth Israel Hospital, Newark, N. J.

were not supposed to be supplied in abundance by the hospital.

As the demand for more nourishments increased, the next step was to increase the orange supply each morning and evening until the ice box in the diet kitchen had one compartment filled with oranges and other food commodities. Even though the charge nurse gave serious consideration to the daily order and supplies were sent as requested, the telephone rang continuously all day and as far into the night as there was someone in the dietitian's office to answer it.

Up to this time, a patient on forced fluids was ordered to drink a lot of water and the many kinds of fruit juices that we now have were not available. An early experience with a special order for forced fluids with fruit juice was with a private patient. Our source of fruit juice at that time was the excess juice from canned fruit. This patient received cherry

juice the first day and from then on it was the only drink he would accept and he demanded several quarts a day. In our effort to please him it was necessary to have cherries appear on the menu more frequently than usual or to find our ice box filled with pans of somewhat shriveled cherries.

Fortunately, as the demand for fruit juice increased, the canneries put out pineapple and other juices in No. 10 cans so that we now have an adequate list of canned fruit juices to choose from. As the number of fruit juices increased, our method of distribution became more complicated and is one that still gives the dietitian much concern.

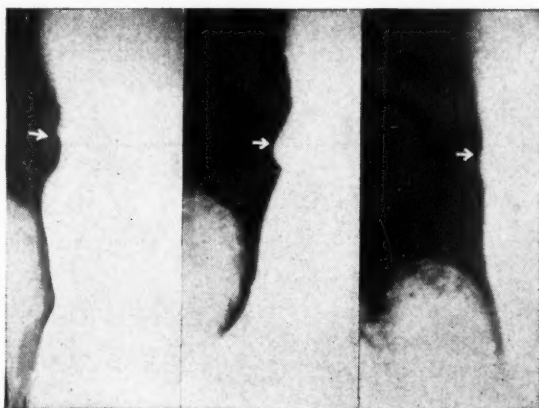
Our first procedure at Newark Beth Israel Hospital was one used by many institutions. Supplies were distributed by an employe from the main kitchen and fruit juices were sent up in quart bottles from the diet kitchen. The requests for more supplies increased daily. These calls were recorded for a time and, after



Views of nourishment unit and truck, one showing dietitian checking cart before it leaves main kitchen.

Prompt Symptomatic Relief in PEPTIC ULCER

...with **PLAIN KNOX
GELATINE (U. S. P.)**



CASE I—FEMALE, 74

Uncomplicated gastric ulcer first demonstrated by Roentgen rays in 1934. Diet and alkalis afforded little relief. Accompanied by loss of weight. Repeated X-ray studies in 1936 and 1937 showed no improvement. She was placed on a diet-gelatine regime in November, 1937. Relief immediate. Gained weight. Roentgen studies in April, 1938 showed no demonstrable ulcer.

CLINICAL research has recently demonstrated the effectiveness of utilizing plain Knox Gelatine (U.S.P.) in treatment of peptic ulcer. In a group of 40 patients studied, 36 (or 90%) were symptomatically improved; 28 of these (or 70%) experienced *immediate relief of all symptoms*. Other than dietary regulation which included frequent feedings of plain Knox Gelatine no medication was given except an occasional cathartic.

NO DANGER OF ALKALOSIS

This regime thus eliminates the "alkalosis hazard" attendant upon continued alkali therapy. In discussing the mode of action by which gelatine brings peptic ulcer relief, Windwer and Matzner* speak of the acid-binding properties by which proteins can neutralize acids, and they state that the frequent gelatine feedings "apparently caused more prolonged neutralization of the gastric juice."

PEPTIC ULCER FORMULA

Empty one envelope Knox Gelatine in a glass three-quarters filled with cold water or milk. Let the liquid absorb the gelatine. Then stir briskly and drink immediately before it thickens. Take hourly between feedings for seven doses a day.

*Windwer and Matzner, *Am. Jl. Dig. Dis.* 5: 743, 1939.

NOTE:

The gelatine used in this study was plain Knox Gelatine (U.S.P.) which assays 85% protein and which should not be confused either with inferior grades of gelatine or with sugar-laden dessert powders, for these latter products will not achieve the desired effects. When you desire pure U.S.P. Gelatine, be sure to specify KNOX. Your hospital can get it on order.

WRITE DEPT. 465



KNOX GELATINE LABORATORIES
JOHNSTOWN NEW YORK

Please send complete details of the Knox Gelatine peptic ulcer regime.

Name _____
Address _____
City _____ State _____

List of Drinks Offered

10 a.m.	Orange Juice
	Pineapple Juice
	Tomato Juice
	Egg Nog
	Milk
2 p.m.	Fruit Punch
	Grapejuice
	Chocolate Malted Milk
	Milk
8 p.m.	Orangeade
	Milk
	Cherry Juice

a study was made of the cost of supplies and the effort spent in answering calls, we decided to establish a central nourishment unit with a full-time maid in charge. We were fortunate in being able to utilize a corner of our main kitchen, which heretofore had been used for storing salads and canned fruits.

We extended the menu of our private patients, giving them the opportunity of choosing nourishment at 10 a.m., 2 p.m. and 8 p.m. The maid in charge prepared all of the nourishment orders for the entire house, delivered them in quart bottles to the wards and then, with the aid of a helper, passed them directly to the private patients. The maid also prepared nourishments for the night, including several eggs and oranges that were left on each floor for an emergency.

Supplies for the night were delivered in bulk by the students in the diet kitchen, with the marked menus to the private floors.

A check was made on all procedures and a cost account kept. Statistics proved that we were spending a little less money including the maid's salary and we were assured of the fact that every patient who was supposed to have nourishment was getting it; in the meantime the busy nurses on the floors were relieved of an extra burden. The only difficulty encountered in this system was that patients frequently changed their minds about the type of nourishment they wanted by the time of delivery.

As a solution to this problem, we purchased several 2 gallon crockery containers with spigots of several colors. These containers are placed on one of the small stainless metal trucks that we have in the kitchen. The maid and helper are now able to go

from room to room offering the patient a variety of nourishments and it is seldom that anyone requests anything that is not on the truck. Juices for forced fluids are left on the floor in the ice box in milk bottles with the number of the patient's room marked on them. Our next improvement will be to leave all forced fluids with the patients in vacuum bottles and to refill them with a variety of the juices desired by the patient.

A check sheet has been worked out so that each morning the charge nurse marks the type of nourishment ordered, such as full or restricted fluids. This enables the maid to

know what to offer the patient. The sheet is kept at the desk on each floor so that any changes in the orders may be made before nourishments are passed again.

It is always wise to carry orange juice on the truck since this is a popular nourishment and helps to eliminate any calls during the day.

All requests are taken care of by the nourishment maid until 4 o'clock. After that time someone from the diet kitchen is assigned to this service and delivers the prepared drinks. This has been a most successful way of meeting a difficult situation and has proved to be economical and efficient as well.

Safety Suggestions

Floors: Keep free of grease and water. Avoid high polishing and waxing. Mop up spilled material at once.

Counters and Table Tops: Keep free of sharp or chipped edges and slivers.

Dishes: Discard cracked or broken dishes. Broken glass or dishes should be cleaned up with brushes or brooms, not by hand.

Stairways: Mark and light well. Provide handrails and nonslip treads. Keep clear.

Trap Doors: Eliminate, if possible; otherwise provide a railing around them with toe boards.

Wash Rooms: Mark plainly and keep clean.

Swinging Doors: Separate doors should be provided for entering and leaving. Doors should be marked and should swing only one way.

Shelves: Do not overload. Place containers securely.

Fans: Completely enclose with wire mesh regardless of location. Portable fans should be placed where they will not fall.

Electricity: Wiring and appliances must be kept in perfect condition.

Trays: Use only smooth trays. Do not overload.

Lifting: In handling heavy objects, lift with legs, not the back. Avoid loading trays too heavily.

Ventilation: Provide adequate ventilation. Keep kitchen from getting so hot that employees will suffer from heat exhaustion.

Chairs and Stools: Check daily for defects that may cause injury to customers.

Refrigeration: Have system checked periodically.

Mechanical Equipment: Guard all belts, pulleys, gears, sprockets, shafting and points of operation that will cause injury. Grinders should be of the narrow neck type fed with a stomper.

Garbage: Store in tight containers and remove frequently.

Packing Material: Burn boxes and packing material daily.

Fire Hazards: Avoid accumulation of greasy rags and scrap materials. Provide adequate protection and insulation around heating equipment. Place fire extinguishers at convenient locations. Keep fire exits clear.

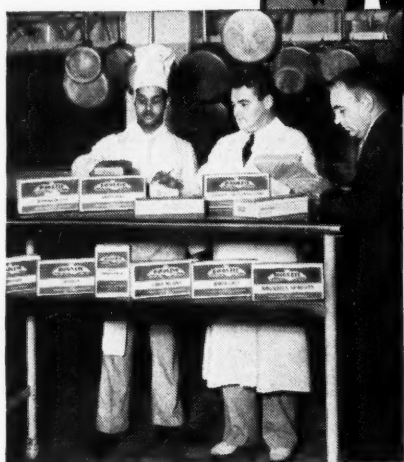
First Aid: Provide adequate first-aid supplies. Have an employee trained in first-aid work. Insist on first aid for all cuts and bruises regardless of how minor. Serious injuries should be cared for by a doctor immediately.

Knives: Keep in one place when not in use. Show employees how to use them properly. This also applies to cleavers.

Shoes: Low heeled shoes for waitresses will prevent many slipping accidents.

Collisions: Teach employees to carry trays so vision will be clear.

Housekeeping: Have a place for everything and keep everything in its place.—*American Restaurant Magazine.*



C. Y. Nickell, center, Purchasing Agent of the Hotel Roanoke, checks over Birds Eye supplies with Lee J. Griffith, Steward, and Chef Fred Brown.

How would you buy foods for a \$100,000 KITCHEN?

ONE HUNDRED THOUSAND DOLLARS spent to equip a kitchen is real money in any language! And the meals that come out of it have to be *good*! Or you're left with a white elephant.

Mr. C. Y. Nickell of the new Hotel Roanoke in Roanoke, Virginia, had just that problem. His kitchen cost a cool hundred thousand. Chef Fred Brown was the kind of flavor magician that hospital dietitians dream about. The catch was to find the foods that would do them justice.

The answer—after a series of painstaking tests—was Birds Eye Foods. Right now the Roanoke uses over 15 Birds Eye items regularly. But here's Mr. Nickell's recent letter.

"A long time ago we made exhaustive tests on the desirability of using Birds Eye Frosted Foods. We came to the definite conclusion that Birds Eye fully answered our needs and we use them on our regular menus and for small parties and large banquets.

"The Birds Eye high standard of quality has never varied as each package contains that uniformity and fine fresh flavor which is so essential in consistently serving fine foods. Their garden freshness is really outstanding.

"Then, too, when we have to prepare extra meals quickly, Birds Eye Foods answer the problem as there is no lost time in their preparation and, due to their freshness, they cook in far less time than ordinary foods."

Mr. Nickell's said just about what we'd like to tell you. Except that there are more than 30 different Birds Eye Fruits and Vegetables—all of 'em delicious. And that they all come washed, cleaned, and ready to cook or serve. Why not test Birds Eye Foods today? Your local distributor has helpful suggestions on many of your food problems.

This month feature **BIRDS EYE ASPARAGUS!**

Tender, flavorful Birds Eye Asparagus comes in 40-oz. cartons all ready to cook, in 4 styles, at 4 price levels.

SELECT TIPS—for table d'hôte service

FANCY TIPS—for general service

JUMBO TIPS—for à la carte and banquet service

ASPARAGUS CUTS—for soups, salads, and cooked dishes



FROSTED FOODS SALES CORP.
250 Park Avenue, New York City

Requisites for a Clinic Dietitian

FRANCES MacKINNON

THAT the food clinic has proved its worth to the hospital organization is evidenced by the establishment of new units each year. The clinics often have started from humble beginnings, sometimes only a table in a corner of the out-patient department where an enterprising doctor has called the dietitian to help a patient understand his dietary care at home.

The medical profession has been appreciative of the worth of this service. Physicians realize that there are significant differences between dietetics as it is practiced in the hospital and as it is practiced in a home. To aid in the continuation of the dietary aspect of medical care after the patient has left the hospital and returned to his own environment is the unique function of the food clinic.

The management of this dietetic program requires the time and thought of a dietitian with a special kind of training. Obviously she must be familiar with the major features of a patient's disease: the disease picture itself, its emotional aspects, the treatment other than dietary that may be needed and the probable time the dietary care will have to be continued. She must appreciate the emphasis to be given the patient's food practices in proportion to other care that may be necessary.

Needs Knowledge of Diseases

In this respect, a familiarity with the hospital routines for the treatment of each disease is the beginning of her understanding. A case of obesity may require only a low calorie diet adapted to the patient's food habits and to his pattern of living. If the case is complicated by cardiac decompensation, however, the emphasis placed on diet assumes a dif-

ferent proportion. Care of the patient's food is only a part of a fairly complicated program of rest and medication. Provision must be made for possible setbacks with advice for feeding during these periods. The dietitian whose hospital experience has made her familiar with the course of such a disease will be able to give practical suggestions to the patient and his family for the dietary management of the illness.

It follows that the clinic dietitian must have some idea of "how the other half lives." In this respect, experience in social service dietetics is invaluable to her. If she has seen families preparing food with a gas burner and two pans as their sole cooking equipment; if she has tried to get a mother to buy economically when there is no storage space for food other than a shelf and a box or so, she will think twice before she talks glibly about the preparation of dainty puddings and buying food in quantity to save money. She should have a catholic appreciation of food and the knowledge that our foreign-born citizens achieve an adequate diet with foods and dishes quite unknown to the native American.

Since the clinic dietitian must be supremely practical in the application of her knowledge, it is something of a paradox to state that she must be a good theorist as well. She is in a particularly good position to aid the doctor in broadening and liberalizing the use of food as a therapeutic measure. In this sense the food clinic serves as a kind of backstage experimental unit. The situation is informal and adaptive and it is easy to work out a plan for a patient on an individualized basis. These digressions from the routine procedures, necessitated by the circumstances of a patient's life, may prove to be more effective than the old plans and may be productive of a speedier convalescence.

The diet clinic also offers an opportunity to study the worth of a dietary procedure, taught and checked with care, over a long period of time. The reports of such studies have taken their place along with those done under the more carefully controlled conditions of the metabolism ward.

There is no clinic dietitian who does not deprecate the loss of valuable time that could be utilized for teaching the patient during the period that he is in the hospital, idle, without the worries of his environment and concentrating on his illness with a kind of single-mindedness that becomes an advantage to him in learning the details of his future care. For years the out-patient clinics have grasped this opportunity to get the diabetic patients together and to teach them in classes while they are still in the hospital. Recently such teaching has been undertaken for other groups of patients as well. Methods of cookery and the preparation of dishes suitable for obese patients and for those with peptic ulcer can be demonstrated in a class when the time involved would make it impossible to give such instruction individually.

Young Doctors Benefit

One cannot enumerate the advantages of the food clinic to the hospital organization without mentioning its function in the training of young doctors. The procedures employed in the clinic are essentially those of an office practice. Many patients who are obese or who suffer from gallbladder disease, constipation or gastritis may never be hospitalized and in the small communities, at least, the doctor will not have access to the services of a dietitian. In these communities he may have to be his own dietitian and, by observing the work done by the diet clinic in the care of his patients, he can learn a great deal that will be of practical significance in the treatment of patients in his own practice.

Miss MacKinnon is dietitian, Diet Therapy Clinic, University Hospital, University of Michigan.

PRESENT VITAMIN STANDARDS AND UNITS

● Early in this decade the first International Standards of Reference and Units for vitamins defined in terms of definite quantities of the standard materials were tentatively adopted by the Permanent Commission on Biological Standardization of the League of Nations. At subsequent meetings this Commission has replaced certain of the original standard materials by the pure vitamins or preparations considered to be better adapted as standards of reference. However, the new units defined in terms of the new standards represent approximately the same biological activities as the original International Units.

Believing that the present units and the standards of reference upon which they are based will be of interest, they have been tabulated and defined:

Vitamin A

The standard of reference (1) is a solution of purified beta-carotene in an inert oil, of such concentration that one gram of solution contains 300 micrograms (0.300 mg.) of beta-carotene. The International Unit of vitamin A is the vitamin A activity of 2 mg. of the standard solution, or 0.6 micrograms of beta-carotene.

Vitamin B₁

The reference standard (2) is the International Standard preparation of thiamin chloride. The International Unit for vitamin B₁ is the antineuritic activity of three micrograms (3γ) of the International Standard.

Vitamin C

The reference standard (1) for vitamin C is a specified sample of crystalline levo-

ascorbic acid. The International Unit for vitamin C is the vitamin C activity of 0.05 mg. of this standard.

Vitamin D

The reference standard (1) for vitamin D is a solution of irradiated ergosterol, prepared under specified conditions at the National Institute for Medical Research (London). The International Unit for vitamin D is the vitamin D activity of 1.0 mg. of this standard solution.

The International System of expressing vitamin values will undoubtedly soon become official for all authoritative agencies which concern themselves with the establishment of vitamin standards and units. Reference standards for riboflavin and nicotinic acid—both of which are of significance in human nutrition—have not been defined. However, the use of units such as micrograms or milligrams of the crystalline compounds to express riboflavin and nicotinic acid values is becoming increasingly prevalent.

The use of vitamin units of definite value permits correlation of various phases of vitamin research, particularly those phases relating to the vitamin contents of common foods and to the quantitative human requirement for these essential food factors. Although vitamin supplementation of the diet may be desirable under certain circumstances, it is apparent (3) that a well planned mixed diet is most suitable for supplying optimal quantities of the vitamins along with the other essential nutrients. The established vitamin values of canned foods (4) serve as an indication of their usefulness in formulating such diets.

AMERICAN CAN COMPANY

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- (1) 1935. Nutrition Abstracts and Reviews, 4, 705.
- (2) 1938. League of Nations Bulletin of the Health Organization, 7, 882.
- (3) 1938. J. Am. Diet. Assn., 14, 1.
- 1938. J. Am. Diet. Assn., 14, 8.

- (4) 1935. J. Home Econ., 27, 658.
- 1935. J. Nutrition, 9, 667.
- 1938. J. Am. Med. Assn., 110, 650.
- 1938. Nutrition Abstracts and Reviews, 8, 281.

We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles. This is the fiftieth in a series, which summarize, for your convenience, the conclusions about canned foods reached by authorities in nutritional research.



The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.

Diabetic Club for Children



Saturday morning cooking class at the Milwaukee Children's Hospital.

A DIABETIC club has been successfully conducted at the Milwaukee Children's Hospital in connection with the weekly Saturday diabetic clinic. Its activities are supervised by the doctor in charge of the diabetic clinic, the medical social worker, the dietitian, clinic nurses and volunteer students in occupational therapy from a local college. The members range in age from 2 to 14 years with officers consisting of a president, vice president, secretary and treasurer elected by the children. A general club meeting is held monthly at which an instructive talk is given by the doctor or dietitian.

Diabetic children report to the clinic on Saturday morning for a checkup. While waiting for their turn to see the doctor and after they have seen him, they work on one of the club's various projects. A student volunteer occupational therapist supervises the work in handicrafts and dramatics. The children are taught to weave, sew, build, paint and draw.

The children made an interesting scrapbook, which was exhibited at the 1938 American Dietetic Association convention in Milwaukee, in which a page or more was devoted to each project carried on during the year. Snapshots taken at the Halloween and Christmas parties and the annual picnic were included. The

The author is assistant dietitian, Milwaukee Children's Hospital, Milwaukee.

children also collected articles on diabetes from newspapers and magazines. The borders of each page, drawn by the members, were significant of the activity described on that page and were all original and clever. New articles are added to the scrapbook as the children discover them.

Group activities hold the greatest appeal because they afford the best opportunity "to help each other over the stumbling blocks," which is the purpose of the club. The children are very much concerned about one another, especially those who are confined to the hospital. They write letters, bring presents and do everything possible to make those in the hospital happy.

Especially popular is the cooking class that is held by the dietitians in the clinic kitchen every other Saturday. The children are taught to prepare simple dishes and, occasionally, to assemble a meal. These dishes give variety to the diet and may be substituted for other articles of food included in their diet. The mothers report that the children have tried the recipes at home and, much to the surprise of everyone, the boys show as much interest as the girls.

A play was presented by the children under the direction of the student volunteer and, at their own suggestion, part of the proceeds was given to the Milwaukee County

MAGNA WERRA

Community Fund which helps to support the Children's Hospital.

The biggest occasion of the year is the annual picnic that is held at the summer home of one of the hospital board members. The doctors, dietitians and nurses who treat the children attend. After an afternoon of playing ball, swimming and boating, the youngsters gather around the camp fire to roast their previously weighed hamburgers. All enjoy hunting for the basket lunches that are packed according to each child's diet prescription. Paper hats, balloons, diabetic candies and various other favors are delightful surprises.

The diabetic club has aided greatly in bringing to the parents a better understanding of diabetes and its hospital and clinical treatment. A periodic checkup of the urinalysis procedure and the technic of giving insulin is made with the parents and older children. In this way any mistakes that they may have been making at home are detected.

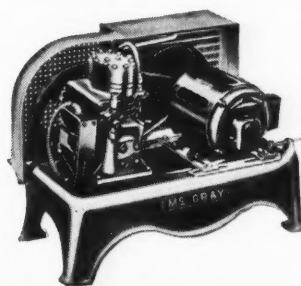
Of even greater value is the encouragement the club gives to the child when he realizes that he too can give plays, speak, cook, play games and, in short, carry on the activities of a healthy normal child.

Children are anxious to learn all they can and their knowledge of the disease and its treatment often amazes visitors to the class.

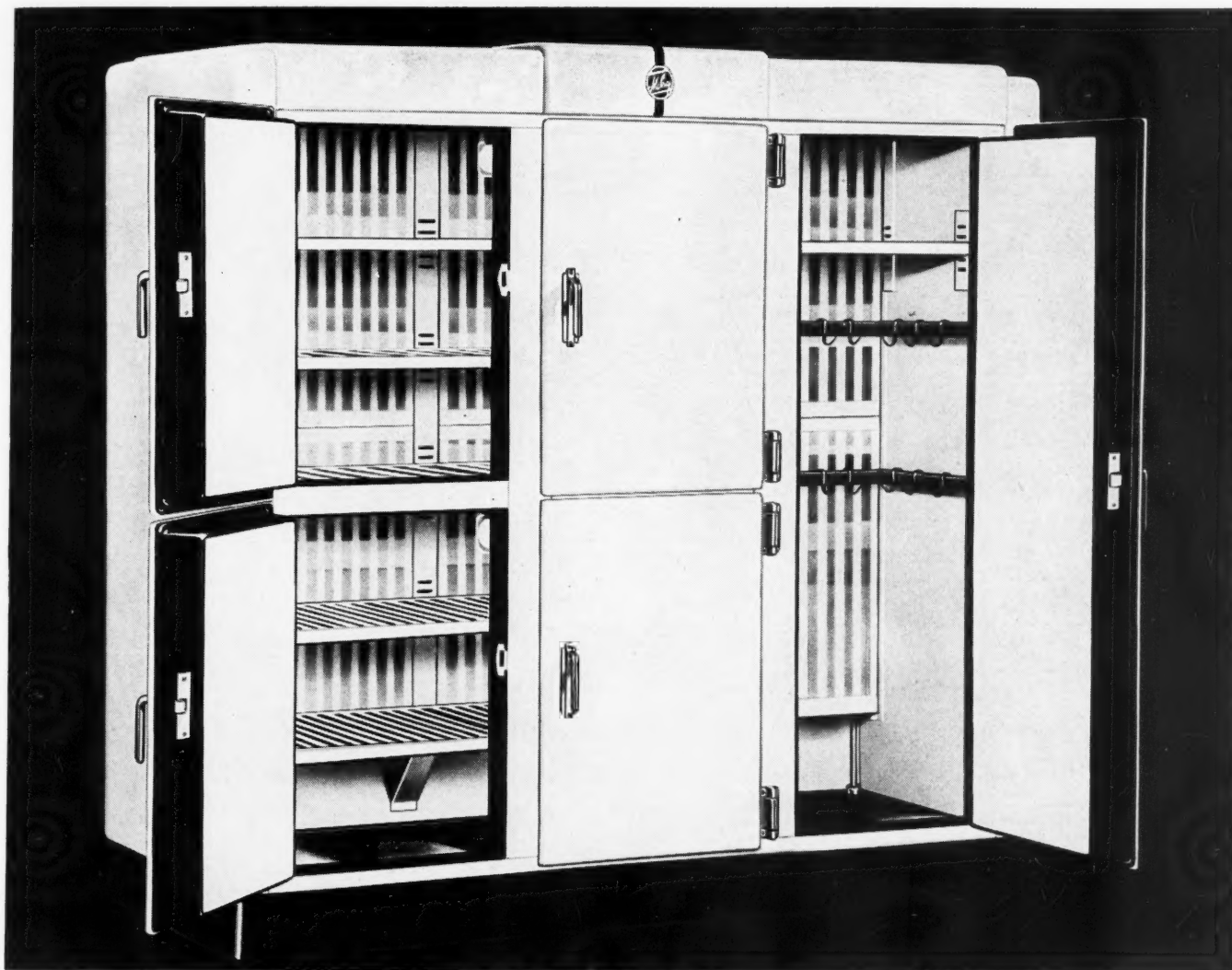
The Children's Hospital diabetic club has been of value not only to the children and their parents but to the hospital as well. A survey was made in which it was found that the hospitalization of diabetic children has decreased to a great extent since the club was organized. It is believed that this may be because of the fact that the children and their parents now have a better understanding of the disease, realize the importance of the doctor's orders and are able to follow them at home. The cost of operating the diabetic club is small when one considers all the good that is derived from its existence.

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September Menus for the Small Hospital

BREAKFAST

LUNCHEON OR SUPPER

Day	Fruit	Main Dish	Main Dish	Potatoes or Substitute	Vegetable or Salad	Dessert
1.	Tomato Juice	Soft Cooked Eggs, Toast	Shrimp and Pickle Rarebit on Toast		Raw Vegetable Salad, French Dressing	Prune Whip
2.	Orange Juice	Bacon, Coffee Cake	Italian Spaghetti With Meat Balls		Tossed Greens, French Dressing	Pear Sauce, Cookies
3.	Baked Apple	Eggs and Sausage, Raisin Toast	Assorted Cold Meats	Potato Salad	Sliced Tomatoes	Fruit Gelatin, Whipped Cream
4.	Grapefruit Juice	Canadian Bacon, Toast	Creamed Asparagus on Toast		Molded Carrot and Pineapple Salad	Pumpkin Pie
5.	Stewed Prunes	Scrambled Eggs, Rolls	Escalloped Oysters	Creamed Potatoes	Pickled Beets	Lady Baltimore Cake
6.	Frosted Raspberries	Shirred Eggs, Muffins	Spanish Rice		Grapefruit Salad	Chocolate Cake
7.	Sliced Bananas	Bacon, Hot Rolls, Marmalade	Beef Hash With Poached Egg		Combination Salad Bowl	Coffee Bavarian Cream
8.	Pineapple Juice	Scrambled Eggs, Toast	Salmon Creole on Toast		Grape and Orange Gelatin Salad	Jelly Roll, Whipped Cream
9.	Orange Juice	Bacon Curls, Apple Rings, Hot Biscuit	Broiled Sweetbreads With Lemon Juice	Parsley-Buttered Potatoes	Frozen Spinach	Sliced Peaches and Cream
10.	Tomato Juice	Broiled Ham, Toast	Kidney Bean Salad	Deviled Eggs	Sliced Tomatoes, Celery, Olives	Fruit Sherbet
11.	Half Cantaloupe	Soft Cooked Eggs, Toast	Escalloped Pork Chop With Potatoes		Sliced Onion and Orange Salad, French Dressing	Floating Island
12.	Grapefruit Juice	Sausage, Muffins	Creamed Chipped Beef on Toast		Frozen Buttered Asparagus	Ambrosia
13.	Baked Apple	Bacon, Coffee Cake	Molded Ham Loaf	Potato Cakes	Sliced Tomato and Deviled Egg Salad, French Dressing	White Cup Cakes
14.	Sliced Bananas	Frizzled Dried Beef, Toast	Spanish Omelet	Creamed Potatoes	Frozen Peas	Fruit Gelatin
15.	Tomato Juice	Shirred Eggs, Corn Muffins	Oyster Soup	Baked Stuffed Potato	Fruit Salad, Mayonnaise	Chocolate Pudding, Whipped Cream
16.	Pineapple Juice	Bacon and Eggs, Toast	Meat Balls in Mushroom Sauce	Mashed Potatoes	Creamed Onions	Half Cantaloupe
17.	Frosted Raspberries	Scrambled Eggs, Hot Corn Bread	Cold Tongue	Potato Salad	Tomato and Cottage Cheese Salad	Vanilla Ice Cream, Chocolate Sauce
18.	Stewed Apricots	Fried Corn Meal Mush, Syrup	Broiled Stuffed Frankfurters	Buttered Hominy	Orange and Water Cress Salad	Chocolate Cornstarch With Whipped Cream
19.	Applesauce	Poached Egg on Toast	Chicken and Olive Loaf	Macaroni Salad	New Cabbage, Cheese Sauce	Ice Cream
20.	Orange Juice	Jelly Omelet, Toast	Liver and Bacon	Buttered-Parsley Potatoes	Green Bean Slaw	Baked Apple With Cream
21.	Figs	Scrambled Eggs, Biscuits	Pork Chop	Mashed Potatoes	Carrots Julienne	Peaches and Cream
22.	Tomato Juice	Soft Cooked Eggs, Muffins	Creamed Codfish	Baked Potato	Stuffed Pear Salad	Pumpkin Pie
23.	Half Grapefruit	Bacon Curls, Apple Ring, Toast	Spanish Omelet	Corn Fritters	Lettuce, French Dressing	Fruit Cup
24.	Prune Juice	Codfish Cakes, Popovers	Welsh Rabbit With Bacon Curls on Toast		Tomato Salad	Coconut Cake
25.	Sliced Bananas	Soft Boiled Eggs, Toast	Baked Lima Beans With Bacon	Brown Bread	Cabbage Salad	Canned Plums, Cookies
26.	Grapefruit Juice	Scrambled Eggs, Toasted English Muffins	Salmon Salad	Potato Chips	Tomato Slices With Cottage Cheese, French Dressing	Ambrosia
27.	Applesauce	Bacon and Eggs, Toast	Baked Hash	Cauliflower	Stuffed Prune Salad	Baked Custard, Wine Sauce
28.	Pineapple Juice	Creamed Chipped Beef on Toast	Chicken à la King on Toast	Shoestring Potatoes	Combination Vegetable Salad	Orange Ice, Cookies
29.	Tomato Juice	Codfish Cakes, Toast	Baked Eggs, Cheese Sauce	Corn Fritters	Spiced Pears	Pound Cake, Hot Chocolate
30.	Frosted Raspberries	Coddled Eggs, Muffins	Cold Sliced Baked Ham	Escalloped Potatoes	Beet Salad, French Dressing	Watermelon

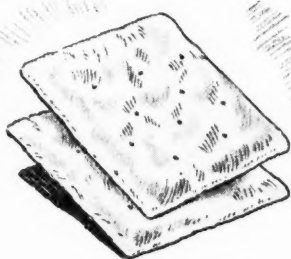
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*Taub, Vitamin Manual

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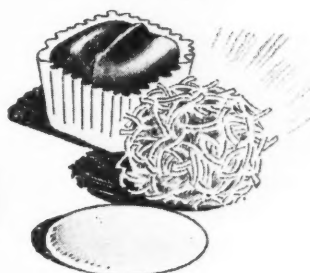
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Sterilizing Medicinal Substances

BENJAMIN LEVIN

THE increasing demand for parenteral solutions, as well as for other sterile medicaments, makes it incumbent upon the institutional pharmacist to familiarize himself thoroughly with the several methods of sterilization and the applications of these methods to the different classes of medicinal substances.

Sterilization by steam under pressure, as carried out in the autoclave, is familiar to most hospital pharmacists. This method is the best for all solutions that are not decomposed by heat, and it covers the more common parenteral solutions, such as boric acid, sodium chloride, dextrose, sodium iodide, sodium citrate, sucrose and sodium lactate.

Autoclave Sterilization

The usual procedure in sterilizing solutions in an autoclave is as follows: The solution to be autoclaved (plus a small excess of distilled water, to allow for evaporation) is introduced into a heat resisting flask. The percentage of excess solvent varies inversely generally in proportion to the volume of the container. The capacity of the flask should be at least one third greater than the volume of the solution in order to prevent splashing of the liquid and consequent wetting of the porous stoppering material during the heating process and in handling. The mouth of each flask should be plugged with nonabsorbent cotton and covered with one or two layers of heavy paper. The paper should be secured by two strips of cotton tape, one just under the lip of the flask and the other about an inch or more below. The capped flasks containing the solutions should be autoclaved for fifteen minutes at a temperature of between 240° and 250° F. under a pressure of from 15 to 17 pounds.

It is preferable that the flasks in

Mr. Levin is pharmacist in the Baltimore City Hospitals.

the autoclave rest on a shelf of non-resinous wood, such as cypress or oak, instead of on metal, since the latter substance retains heat longer and thus increases the time required for cooling the solution. Furthermore, a metal shelf, concentrating an excess of heat on the underside of the flask, will bring about the caramelization of dextrose solutions and may have a deleterious effect on other solutions.

After sterilization, the autoclave should not be opened until the pressure returns to zero. The gradual cooling is necessary in order to prevent the violent ebullition that would occur in the liquids if the pressure were too suddenly released by the opening of the autoclave door. The great advantage of the autoclave, of course, lies in the fact that the steam under pressure supplies a moist heat of considerably higher temperature than that obtained by boiling.

Streaming Steam Sterilization

Certain medicinal substances, however, while they can successfully withstand a boiling temperature (212° F.), are decomposed at the temperature of the autoclave (from 240° to 250° F.). This is particularly true of solutions containing organic material. A preparation of this sort can be conveniently sterilized in an Arnold sterilizer, which utilizes streaming steam without pressure. This process, also known as intermittent or fractional sterilization, requires a sterilization period of from thirty to sixty minutes (at close to 212° F.) on each of three successive days; between heatings the solution is kept at a temperature approximating that of the incubator.

The process of incubation is of utmost importance since it allows the dormant spores that have resisted the previous day's heating to develop in order that they may be destroyed by

the second or third sterilization. Although three sterilizations are usually sufficient for the destruction of microorganisms by this process, certain spore bearers have been known to resist exposure. For this reason it is good practice to run tests for sterility on finished solutions that have been subjected to sterilization by unconfined streaming steam.

Successful sterilization in either the autoclave or the Arnold steam sterilizer does not necessarily ensure a reaction-free solution. Pyrogenic substances introduced through the medium of unclean glassware, contaminated chemicals or contaminated distilled water will cause pyrexia and other untoward symptoms in spite of sterilization. Therefore, scrupulous care should be used in cleaning glassware in which solutions are to be sterilized. Similarly, chemicals or other substances from which solutions are prepared should be kept as free from contamination by dust and moisture as possible.

Distilling the Water

The water used in solutions should be freshly distilled from a still equipped with adequate baffles in order to facilitate the removal of any pyrogenic substances contained in the raw water which might otherwise be mechanically carried over into the distillate. In this connection, it might be well to explode the ancient myth of the necessity of triple-distilled water in parenteral solutions. A single still, provided that it is adequately baffled, will supply water of a quality suitable for intravenous solutions. (Impure water supplies, found in some localities, may require a hard water still or other especially designed equipment.)

The use of steam sterilization will not serve for oil, fats or waxes. Embedded in the oil or fat, the organ-

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ism is protected from moist steam, the actual sterilizing agent of the autoclave. Naturally, the heat of the autoclave alone with its usual limit of 250° F. is scarcely sufficient to effect sterilization. In addition, an oily preparation sterilized in the autoclave will usually be contaminated with droplets of water from the condensed steam. Hence, it is necessary to sterilize substances of this nature by dry heat. This process is best carried out

in a hot air oven at a temperature of 320° F. for a period of one hour for a small volume of oil, and two hours for one liter or more.

In the sterilization of ointments, three points must be considered. First, the ointment jar should have an aluminum top, since a lacquered tin, bakelite or average composition cap will be affected by the heat of the oven. Second, the top should be left loose during the process of ster-

ilization, in order to allow the expanded air to escape. Third, in cases in which the ointments contain insoluble ingredients, only small amounts, much less than the capacity of the ointment jar, should be sterilized. This procedure is suggested by the fact that when the ointment melts, separation of the medicaments will occur, resulting in an uneven distribution of the medicinal substance through the base. However, if the amount of ointment sterilized is small, the doctor or nurse, when about to use the preparation, can easily render it homogeneous by stirring it briefly with a sterile applicator or tongue blade.

In addition to sterilization by autoclaving, flowing steam and dry heat, there are two methods designed especially for the sterilization of those solutions that are decomposed by even small amounts of heat.

One of these methods is filtration, by means of a bacterial filter of the Mandler, Berkefeld or Seitz type. Before being used the filter should be tested for leaks resulting from defects, and should be thoroughly cleansed and sterilized. This type of filtration is far from an ideal method for, in addition to the possibility of nonsterile solutions, there is the additional disadvantage of the occasional adsorption of medicaments on the filter, resulting in a lowered concentration of the solution.

The other method that may be used for substances that are decomposed by heat is preparation under as nearly aseptic conditions as possible by dissolving a pure chemical of reagent quality in sterile water or sterile saline solution. Neither this method nor the one previously described, however, ensures a sterile product, so that, if time permits, sterility tests should be run on solutions made by either process.

Finally, it is well for the pharmacist to remember that sterilization is an exact science and not an occult art. If the correct method is chosen for each substance; if the glassware is clean, and if the water is freshly distilled and pyrogen free, the resulting sterile medicaments will be of a uniformly high standard and the subsequent occurrence of reactions resulting from the use of such preparations, a rarity.

Saving Labor in the Pharmacy

MEYER J. GILL

IT IS imperative for a pharmacist to have a price card index system that will give him accurate information as to the cost of crude drugs and chemicals and of the value of the finished preparation, so that he can readily see whether it pays him to buy the finished product or to manufacture it himself. However, before making a decision he must consider carefully the fact that, while in many cases the cost of the crude drugs and chemicals may be cheaper, the time and labor entailed in manufacturing the product may make it prove more expensive ultimately.

Since the hospital pharmacy, despite its importance, is usually considered but a small part of the hospital by the administrator, it is sometimes difficult to obtain money for the purchase of equipment. The hospital pharmacist might well ask the administrator to appoint a prominent pharmacist in the community to act as an adviser when the question of additional equipment arises. If the request is justified, he, as an experienced pharmacist, will agree with the proposed expenditure and advocate it.

An ointment mill is an essential piece of equipment in a hospital pharmacy. Many pounds of ointment are made during the period of a month in a large institution, and buying petrolatum and waxes in large amounts results in quite a saving. If the hospital formulary con-

tains several compounds in capsule form, time and money are saved by the purchase of a capsule filling machine capable of filling 24, 48 or even more capsules at a time, as well as separating and capping them.

Another labor-saving device is a mixing machine that mixes and whips fluids in large amounts. This machine is similar to the one used by bakers in mixing dough. The most important machine in the pharmacy at Beth Israel Hospital, Newark, N. J., is a little mixer that I use for many purposes. It consists of a small motor to which several rods with short leaf-like propellers in the middle and at the end can be attached. I have also attached to the electric cord leading to this motor a rheostat that controls various fixed speeds. Another important piece of equipment is a still for making distilled water. A small filtering apparatus made by the carpenter has been a great help. This enables me to filter 15 gallons at one time.

An adequate refrigerator is another essential piece of equipment inasmuch as pharmacists are responsible for storing serums that must be kept at certain temperatures.

In closing let me reiterate that even though a pharmacy possesses much equipment, it does not necessarily mean that all drugs and pharmaceuticals should be manufactured within the hospital. The pharmacist should be sure that he is saving time and labor as well as cost before he decides to make his own preparations.

Mr. Gill is the chief pharmacist at Beth Israel Hospital, Newark, N. J.

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When Pharmacists Get Together

RUSSELL H. STIMSON

THE hospital pharmacy has become one of the most useful therapeutic facilities in the institution, and hospital pharmacists are considered specialists in their particular field. In addition to being a specialist, the pharmacist is a business and professional man. The administration of a hospital looks to him for help from a business standpoint, while the physicians and nurses look to him for professional help. Therefore, the pharmacist should endeavor to meet these requirements at all cost.

The American Medical Association and the American College of Surgeons have already suggested standards for hospital pharmacies. They have recommended that the handling of drugs in a hospital should be adequately supervised by a registered pharmacist. These pharmacists must keep up with new ideas and knowledge pertaining to their profession

The author is the pharmacist at Huron Road Hospital, East Cleveland, Ohio.

and there are several ways in which this may be accomplished.

First, the pharmacist owes it to himself and to his hospital to be an active member of the American Pharmaceutical Association. He should attend its yearly conventions whenever possible. He should read the association journal and the *Journal of the American Medical Association*.

Second, the pharmacist should read all publications and literature pertaining to new drugs and remedies. This is important, because he must be able to discuss these new drugs intelligently with physicians.

Third, and most important, he should meet regularly with other hospital pharmacists of the community in order to promote the spirit of unanimity and friendship that is essential to the dignity and success of the profession. Through such meetings new ideas are created and discussed and these may be a direct means of improving the pharmaceutical service in the institutions. Most of us

cannot attend all yearly conventions because of geographical locations but we can attend the meetings within our own communities.

If these meetings are to be of real value, they should be held at the various hospitals so that visiting pharmacists may obtain first-hand information by observing each other's methods. The advantages of observation may be illustrated by the following examples of interchanges of ideas that resulted from meetings of our own hospital pharmacists' society.

The group was meeting at one of the local hospitals. The pharmacy was small and compact and the pharmacist had to utilize all the space to the best advantage. He placed his tablet stock in French square bottles so that they could be stored horizontally, thereby using less space. One of the visiting pharmacists took this idea back to his own hospital and created that much needed shelf-room.

At another meeting, one person noted that the sterile solution of boric acid was packaged in Erlenmeyer flasks and the sterile glucose or saline solutions were packaged in Florence flasks. Knowing that this method of packaging sterile solutions would be another means of identification and precaution, he adopted the idea in his pharmacy.

Some of the meetings may be dinner meetings and others may be held in the evenings. Occasionally a guest speaker may be obtained. This guest speaker may be a physician, nurse, research worker, accountant or administrator. An interesting scientific motion picture may be shown. However, most of the subjects should be presented by the pharmacists themselves. Such subjects as sterile solutions; narcotic control; drug purchasing; instrument and professional stores; drugs for anesthesia; pharmacy internships; pharmacists; perpetual inventories, and numerous other subjects are of interest to a progressive pharmacist.

There is another consideration that is important when holding local



View of the drug dispensary at Allegheny General Hospital, Pittsburgh. Cabinets are finished in dull gray enamel and have chromium plated pulls and label holders. Upper cabinets have sliding doors and adjustable shelves. Lower cabinets have drawers divided into compartments.

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meetings. The program should be well planned and the pharmacists holding these meetings should have real objectives in view, such as the following: (1) to promote the advancement of pharmaceutical sciences; (2) to provide a more cooperative understanding of the problems in hospital pharmacy; (3) to elevate the status of hospital pharmacy, and (4) to encourage better cooperation

with other members of the staff, the physicians, nurses and hospital administrators.

The only way that a hospital pharmacist will know his fellow men is to have meetings with them. Let us have local meetings, state meetings and national meetings. It is this type of organization that will keep the profession of hospital pharmacy up to a high standard of service.

NOTES AND ABSTRACTS

By Carl C. Pfeiffer, M.D., Department of Pharmacology
University of Chicago

"Nostal"

• It was stated in this column in the June issue that nostal (isopropyl bromallyl barbituric acid) might be undesirable because of side actions. This was based on the work of H. Oettel and A. Krautwald of the Berlin Pharmacologic Institute who found that (in dogs) "habituation was surprisingly rapid." These findings, however, were only apparent and were based upon the fact that nostal is rapidly destroyed in the body. No abstinence symptoms could be detected and, hence, the marked tolerance described by these workers is of no significance as regards the ordinary clinical dosage. Nostal can, therefore, take its place based on duration of action between alurate (allyl-isopropylbarbituric acid) and amytal (isoamylethylbarbituric acid) as a useful barbiturate.

Bromides

• The recent recognition of bromide psychoses and bromide delirium as a clinical entity should cause the thinking physician to write "non rep." on his bromide prescriptions. While an occasional prescription does not result in delirium, repeated refilling of bromide prescriptions may have this result. Levin states that of 1399 first admissions to the Harrisburg State Hospital, Harrisburg, Pa., there were 34 cases of simple bromide delirium. After the bromides were discontinued, the length of time required for the delirium to disappear varied from a period of two to six weeks.

Tod and Stalker state that many patients on admission to the Royal Edinburgh Hospital are in a toxic physical and mental state owing to the high level of their blood bromides. During the last four years at least 10 cases of frank bromide psychosis have been ad-

mitted. Two of these died from bromide intoxication.

Cheavens and his associates in Dallas, Tex., studied the blood bromide levels of 555 consecutive hospital admissions. They found 23 patients with elevated blood bromides. Hallucinations were present in 16 of 17 patients whose bromide level was higher than 150 mgm. per hundred cubic centimeters. In contrast to this, hallucinations were present in only one patient in a group with less than 150 mgm. per hundred cubic centimeters.

Treatment should consist of removing the source of the bromides and placing the patient on bed rest for the duration of the mental disorder or toxemia. Sedation should be limited to physical means, such as hot baths, but if drug sedation is needed, paraldehyde should be instilled into the stomach by nasal tube or given rectally. The patient should have adequate nursing care and attempts should be made to increase the intake of chlorides and water. In the absence of any impaired kidney function, large doses of NaCl may be given 4.0 gm. t.i.d.

Toenhart, working at Madison, Wis., used the fact that hydrobromic acid is excreted in the gastric juice to shorten the period of recovery from bromide psychosis. He used the gastric negative suction apparatus (Wangensteen) to remove bromide ion (HBr) from the stomach while he gave the patient liberal supplies of NaCl and water by the subcutaneous and intravenous routes. The patient was entirely well six days after starting this treatment. Although he did not have many cases, nevertheless, he was able to show that it is possible to remove as much as one or more grains of bromide from the stomach in an eight hour period.

While the rôle of bromides in toxic psychoses may be overemphasized at

present, the main factors to be watched during bromide therapy are as follows: (1) the daily chloride intake should be adequate; (2) renal function should be good; (3) fluid intake should be adequate; (4) patients over 40 years of age should be watched carefully and should have occasional blood bromide determinations.

Watermelon Diuresis

• Roby and his co-workers at the University of Chicago have recently studied an old folklore remedy for anuria, namely, watermelon juice and seeds. These workers, using well-controlled experiments in trained bladder-extrophied dogs, find that the diuretic effect results principally from the ingestion of a large amount of fluid which, owing to its sugar content, is practically isotonic with the body fluids. Fresh watermelon juice and its distillate had a slightly greater diuretic effect than did distilled water or juice from old melons. This was ascribed to a mild volatile irritant principle, and the diuretic effect disappeared when the melons were stored in the icebox for one month. The water-alcohol and ether extracts of the juice had no diuretic potency. Extracts of ground up seeds were also lacking in any diuretic effect.

Dihydrotachysterol (A.T. 10)

• This sterol raises the blood serum calcium because of its similarity to vitamin D. It is more potent than vitamin D and has proved of great value in the treatment of postoperative tetany and also in cases of spontaneous parathyroprival tetany.

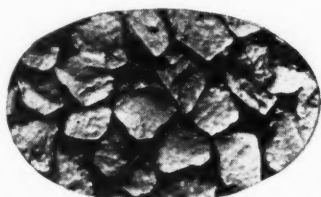
The medication is given orally in doses of $\frac{1}{2}$ to 2 cc. daily; calcium therapy in the form of the gluconate is also usually given in the form of 2.0 gm. t.i.d. midway between meals.

Jacobi and Tigges, working in Germany, find that even acute cases of parathyroid insufficiency respond rapidly to dihydrotachysterol treatment. Idiopathic tetany with normal blood calcium responds well to the treatment, but tetany caused by inflammatory disease of the intestine where the calcium is not absorbed does not respond. A patient with a normal serum calcium was placed on large doses of dihydrotachysterol for two years without any signs of intoxication or any rise in the serum calcium. There was no fall in calcium content when the medication was discontinued.

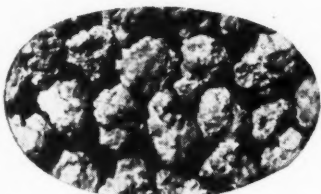
The expense of the medication is its biggest disadvantage at present, since the cost per patient is usually from 50 cents to \$1 per day.



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for all Rebreathing Equipment



Ordinary Soda Lime granules magnified. Note smooth surface and angular shape which permits "packing" in apparatus.



Mallinckrodt Soda Lime Moist granules magnified. Note "knobby" surface which increases absorptive area and globular shape which helps to prevent dense "packing."

• **EFFICIENCY** Improved porosity, increased surface for absorption, moisture carefully balanced to insure stability—all make for rapid, efficient, long sustained removal of carbon dioxide.

• **COMFORT** Granules are especially processed to resist abrasion and dusting, and chemically balanced to prevent gumming and caking. Their globular shape and standardized size insure against undesirable "packing" in the apparatus with consequent obstruction to free flow of air. Physically and chemically controlled for the comfort of the patient.

• **CONVENIENCE** SODA LIME MOIST is available either in 4-8 or 8-14 mesh. The 7-lb. container has a special opening for pouring material without spilling into canisters of rebreathing machines. Efficient resealing device protects unused contents. The 35-lb. economy-size can has a convenient spout, easily attached, the spout itself having a small screw cap for re-sealing. When empty, this container becomes a useful and sturdy hospital pail, with its full bail handle and gray finish to harmonize with surroundings.

AVAILABLE FROM YOUR USUAL SOURCES OF SUPPLY

Write on your hospital stationery for a liberal sample for proof of the multiple advantages of Soda Lime Moist. Please specify mesh desired.

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Monthly News Review

Vol. 53

August 1939

No. 2

11 Organizations Form Advisory Council on Medical Education

An Advisory Council on Medical Education was formed in Chicago on June 24 by 11 national organizations concerned with the training of physicians to meet present day needs for medical care.

Dr. Willard C. Rappleye, dean of the faculty of medicine of Columbia University, was elected president, and Dr. Robin C. Buerki, director of study of the Commission on Graduate Medical Education, was chosen secretary-treasurer. Dr. Maurice H. Rees, dean of the school of medicine of the University of Colorado, was elected vice president.

Member Organizations Represented

The organizations now represented on the advisory council and the number of representatives of each are: Association of American Medical Colleges, 3; American Hospital Association, 3; Catholic Hospital Association, 1; Federation of State Medical Boards of the U. S. A., 3; Advisory Board for Medical Specialties, 3; National Board of Medical Examiners, 1; American College of Physicians, 2; American College of Surgeons, 2; Association of American Universities, 2; American Association for the Advancement of Science (division of medical sciences), 1; American Public Health Association, 1; American Protestant Hospital Association, 1; Association of American Colleges, 2. There are a total of 25 representatives from all the member organizations.

Among the important problems considered by the council at its first meeting were those of proper educational standards of hospital internship, adequate training for the specialist, sound programs for the continued education of physicians in practice, modifications in college preparation for medical studies, the simplification of the procedure for licensure in the 48 states and the status of training of graduates of foreign medical schools. Special committees were appointed to study these various questions and to report conclusions to the advisory council.

Coming Meetings

July 31-Aug. 12—Southern Institute for Hospital Administrators, Duke University, Durham, N. C.
Aug. 13-15—National Hospital Association, New York City.
Aug. 27-Sept. 1—American Dietetic Association, Ambassador Hotel, Los Angeles.
Aug. 30-Sept. 2—American Congress of Physical Therapy, Hotel Pennsylvania, New York City.
Sept. 15-16—Institute for Hospital Administrators, University of Chicago.
Sept. 11-15—American Congress on Obstetrics and Gynecology, Cleveland.
Sept. 19-23—International Hospital Association, Royal York Hotel, Toronto.
Sept. 21-22—Canadian Hospital Council, Toronto.
Sept. 23-24—American Protestant Hospital Association, Toronto.
Sept. 24-25—American College of Hospital Administrators, Toronto.
Sept. 25-29—American Hospital Association, Toronto.
Oct. 16-20—American College of Surgeons, Philadelphia.
Oct. 26-28—National Society for the Prevention of Blindness, Astor Hotel, New York City.
Dec. 1-2—Kansas State Hospital Association, Jayhawk Hotel, Topeka.
Feb. 22-24—Texas Hospital Association, San Antonio.
March 7-9—New England Hospital Association, Hotel Statler, Boston.
March 28-30—Southeastern Hospital Conference, Edgewater Gulf, Biloxi, Miss.
April 2-4—Ohio Hospital Association, Columbus.
April 5-7—Carolinas-Virginias Hospital Conference.
April 8-11—Association of Western Hospitals, Hotel Biltmore, Los Angeles.
April 25-26—Mid-West Hospital Association, Kansas City, Mo.
May 1-3—Tri-State Hospital Assembly, Hotel Stevens, Chicago.
May 8-10—Hospital Association of Pennsylvania, William Penn Hotel, Pittsburgh.
May 22-24—Hospital Association of the State of New York, Buffalo.

All Pittsburgh Hospitals Join Plan

All Pittsburgh hospitals are now members of the Hospital Service Association of Pittsburgh, Mercy Hospital having joined last month to complete the list. Enrollment in this plan is now well past 100,000 persons.

A.M.A. Indictment Thrown Out

The indictment brought by the U. S. Department of Justice against the American Medical Association and a group of physicians has been thrown out by Justice James M. Proctor of the District of Columbia court. Justice Proctor upheld the demurrer which argued that medicine was a learned profession and not a trade. Justice Department officials indicated an appeal would be taken to a higher court.

Four Million Are Now Enrolled in Hospital Care Insurance Plans

A total of just over 4,000,000 persons was enrolled in hospital care insurance plans that are fully approved or approved as to form of organization, according to quarterly statements compiled by the Commission on Hospital Service. This represents a growth of 571,000 members since the previous report on April 1.

The largest growth was recorded by the two plans that have recently had to reduce temporarily their payments to hospitals, namely, New York and Boston. The former took in 190,000 new members to bring its total to 1,399,000, while the latter accepted 42,000 giving it a grand total of 207,000. Other plans with enrollments of over 100,000, together with their enrollments on July 1, are: Minnesota, 281,000; Cleveland, 215,000; Philadelphia, 141,000; New Jersey, 146,000; Chicago, 131,000; Rochester, 121,000; Pittsburgh, 121,000; North Carolina, 108,000, and New Haven, 103,000.

The largest growth during the past three months was recorded by New York and Boston, as stated, followed by Philadelphia, 40,000; Cleveland, 31,000; Pittsburgh, 27,000, and New Haven, 21,000.

Administration Students Find Posts

A wide variety of locations have been found by the students who finished their academic work in the University of Chicago course in hospital administration in June. Administrative internships are held by Sister M. Adele at Evanston Hospital, Evanston, Ill.; by James Stephan at New Haven Hospital, New Haven, Conn., and by Martha Lockman at Elizabeth Steel McGee Hospital, Pittsburgh. Dr. Gordon Meade is assistant director at Strong Memorial Hospital, Rochester, N. Y., and Lawrence Bradley is an assistant at the same institution. Dr. Luis Gonzales Ramirez and Dr. Ramon H. Senariz are returning to Puerto Rico to take charge of new government hospitals being built there. Dr. Herbert T. Warner is assistant director at the Roosevelt Hospital, New York.



Every Physician has frequent use for an Effective Germicide

'MERTHIOLATE' (Sodium Ethyl Mercuri Thiosalicylate, Lilly), noteworthy for its germicidal activity, sustained effect, and tissue compatibility, meets every requirement. It is recommended for deep-skin and delicate mucous-membrane disinfection, for the treatment of infections of the nose, throat, genito-urinary tract,

and various tissue surfaces. Included in the group of 'Merthiolate' preparations are the solution, tincture, ointment, jelly, ophthalmic ointment, suppository, and cream. The maintenance of adequate stocks of the important therapeutic agents in prescription demand is the responsibility of every hospital pharmacy.

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Chicago Institute Speakers Announced; Eleven States Represented at Columbia

The seventh annual institute for hospital administrators, sponsored by the American Hospital Association with the assistance of the American College of Hospital Administrators and local groups, is to be held at the University of Chicago, September 5 to 16, inclusive.

Among the lecturers will be Dr. G. Harvey Agnew of Toronto; Caroline V. Barrett, R.N., of Montreal; Dr. Robin C. Buerki of Chicago; Miriam Curtis, R.N., of Northampton, Mass.; E. M. Geraghty of Baltimore; James A. Hamilton of New Haven, Conn.; Charles A. Lindquist of Elgin, Ill.; Dr. Malcolm T. MacEachern of Chicago; H. V. Mansfield of Nashville, Tenn.; Dr. Fraser D. Mooney of Buffalo, N. Y.; William D. Morgenstern of Chicago; C. Rufus Rorem of Chicago; William H. Spencer of Chicago, and Dr. Peter D. Ward of St. Paul.

A new feature of the institute this year will be group conferences held on Saturday afternoon and Sunday morning. Attendance at these conferences will be optional, but outstanding authorities have been engaged to conduct them.

Ninety-three registrants attended the first New York Institute for Hospital Administrators at Columbia University from June 19 to July 1. They represented eleven states from Georgia to Maine. Five persons from outside the United States were in attendance. An alumni association was formed on the last day with the Rev. John J. Curry of the Catholic Charities of the Archdiocese of New York as president.

Laundry Managers to Meet

The first convention of the National Association of Institutional Laundry Managers is to be held in Atlantic City, N. J., September 29 to October 1. Hospitals are invited to send their laundry managers. Exhibits of modern machinery and supplies and an extensive program on subjects of laundry operation and management in hospitals, hotels and other institutions will be featured. The association estimates that there are 6331 institutions operating power laundries, as follows: hospitals, 4262; hotels, 1290; institutions, 703, and industries, 76. They state that these laundries employ about 150,000 people.

Clinical Aspects of Dietetics Will Be Considered by A. D. A.

Outstanding papers on the clinical aspects of dietetics as well as unusual entertainment will feature the twenty-second annual meeting of the American Dietetic Association which will open on Monday, August 28, at the Ambassador Hotel, Los Angeles.

Among the speakers on clinical subjects will be Dr. Eaton M. McKay, Scripps Metabolic Clinic, La Jolla, Calif.; E. M. Chace, U. S. Department of Agriculture; Dr. Albert H. Rowe, Oakland, Calif.; Agnes Faye Morgan, University of California; E. Neige Todhunter, Washington State College, Pullman; Margaret L. Fincke, Oregon State College, Corvallis, and Herbert M. Evans, University of California.

Special trips through the Rocky Mountains and down the Pacific Coast have been arranged.

Successful Fund-Raising Campaigns

Two successful fund-raising efforts by hospitals were recently completed in Minneapolis and Texarkana, Arkansas-Texas. The Northwestern Hospital, Minneapolis, has obtained subscriptions of \$225,000 to replace an outmoded 50 bed wing and to modernize other units of the hospital. At Texarkana, pledges of \$130,000 were obtained to make possible the construction of a modern four story unit to replace the present antiquated building of the Michael Meagher Memorial Hospital. To the campaign receipts, the board of trustees expects to add \$45,000, thus bringing the total for the new building to \$175,000. Although the hospital is directed by the Sisters of Charity of the Incarnate Word, the campaign was a community-wide effort and leadership was provided by nonCatholics. Both of these campaigns were directed by Ward, Wells and Dreshman of New York.

Foreign Authorities to Participate

An institute for the consideration of blood and the blood-forming organs is to be held at the University of Wisconsin Medical School, September 4 to 6. Outstanding speakers from England, Denmark and all parts of the United States are planning to participate in the sessions.

Gifts for Philanthropy Decline 10.5 Per Cent in Six U. S. Major Cities

Total publicly announced gifts and bequests for philanthropic purposes in six major cities of the United States declined approximately 10.5 per cent for the first six months of 1939 as compared with the same period of 1938, it was revealed today in a statistical report published by the John Price Jones Corporation, public relations and fund-raising counsel.

The study shows that gifts and bequests publicly announced in the six large cities total \$45,379,987 for the six month period as compared with a total of \$50,713,219 for the first six months of 1938. The cities for which the gift record has been compiled are: New York, Washington, Chicago, Boston, Baltimore and Philadelphia.

According to the report New York leads cities with a total of \$17,860,167, followed by Chicago, with a total of \$14,283,909. Totals for the other cities are: Boston, \$6,271,746; Philadelphia, \$5,352,485; Baltimore, \$995,276, and Washington, \$616,404.

Gifts and bequests for 1939 by classification are:

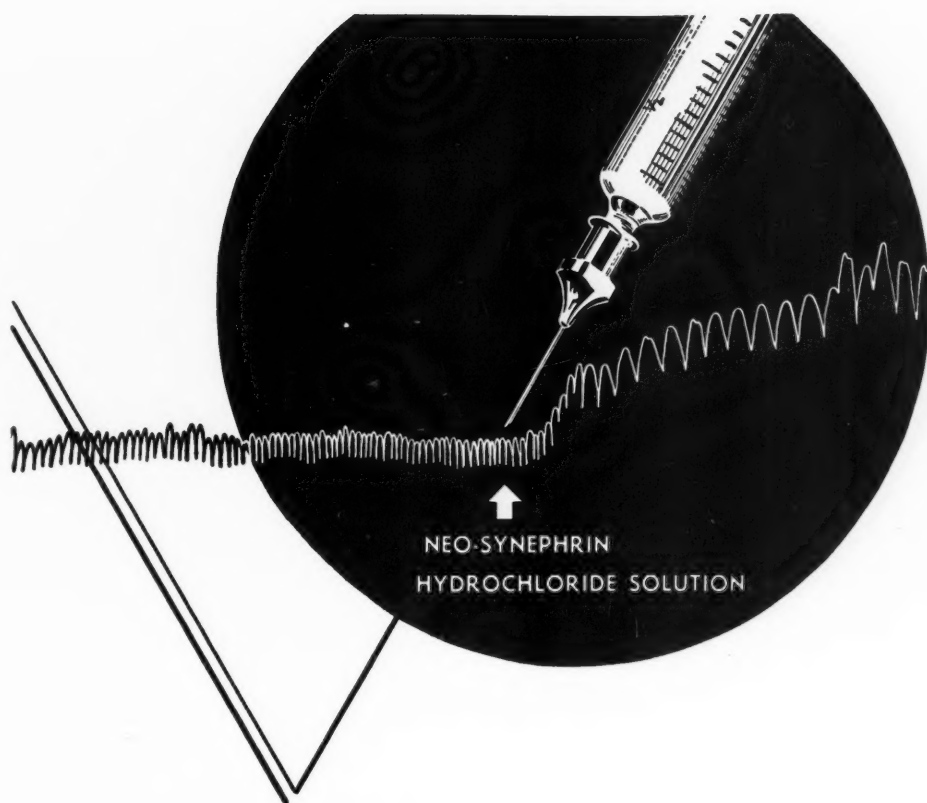
	1939
Education	\$16,088,560
Organized relief	14,735,271
Health	2,814,199
Play and recreation	108,102
Fine arts	5,855,172
Miscellaneous reforms	274,000
Religious	2,216,122
Foreign relief	3,288,561
Total	\$45,379,987

Legalize Medical Insurance

Bills providing for voluntary health insurance plans covering physicians' services have been passed by the Pennsylvania legislature. These bills were sponsored by the Medical Society of Pennsylvania.

Combine Hospital Departments

The departments of psychiatry and neuropsychiatry at Michael Reese Hospital, Chicago, were combined July 1 under the direction of Dr. Maxwell Gitelson, full-time attending psychiatrist. Plans for the opening of an inpatient psychiatric unit, in which both private and ward psychiatric patients will be hospitalized, are nearing completion and the unit will probably be opened in a few months.



When the Blood Pressure Falls

IN ACUTE hypotension during or after extensive surgery, spinal anesthesia, prolonged anesthesia, trauma or hemorrhage, a prompt and effective means of restoring the blood pressure is the subcutaneous administration of

One Per Cent Sterile Solution of

Neo-Synephrin Hydrochloride

(laevo-alpha-hydroxy-beta-methyl-amino-3-hydroxy-ethylbenzene hydrochloride)

Not only is the pressor effect rapid, but it is extended over a period of from one to two hours.

The low toxicity and relative freedom from side effects are some distinguishing features which recommend Neo-Synephrin Hydrochloride for raising blood pressure.

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Supplied in rubber-capped vials containing 15-cc of a sterile 1% solution. Average subcutaneous dose: 0.5 cc.



District of Columbia Needs 250 Additional Hospital Beds

An addition of 250 beds to the facilities of general hospitals in the District of Columbia is recommended in a recently published survey. The chapter on hospitals was prepared by Dr. Vane H. Hoge and Dr. F. C. Smith of the U. S. Public Health Service.

"While there appears to be no acute shortage of hospital beds at the present time," the conclusion states, "it is evident that the factors of increasing population, obsolescence of existing facilities and an increasing hospital and health consciousness on the part of the general public will demand that additional facilities be provided within the near future, both for private and indigent patients.

"It is therefore recommended that at least 250 additional beds for general and surgical cases be provided by the city government as soon as possible. In the meantime, overcrowding of this type of accommodation in Gallinger Hospital should be relieved by utilization to a larger extent of unused beds in voluntary hospitals."

Since the survey was made, the new Doctors' Hospital has been constructed.

Enlarge Orthopedic Hospital

The new wing of the House of St. Giles the Crippled, Brooklyn, N. Y., comprising an enlarged and reconstructed orthopedic hospital, was opened last month with appropriate ceremonies. Some \$200,000 has been spent in adding a modern out-patient department and in providing 25 additional beds. The modernization program likewise includes a new laundry, kitchen, operating suite and renovations on the old building. William T. McCarthy was the architect and C. F. Neergaard, the consultant.

Pass New Nurse Practice Act

A new nurse practice act has been passed by the California state legislature. The act sets up an advisory council to the board of nurse examiners, representing the California State Medical Association, the Association of California Hospitals, the Western Conference of the Catholic Hospital Association, the California League of Nursing Education, the California Organization for Public Health Nursing, the California State Nurses' Association and the California State Education Association. A thirty-six month curriculum is required of nursing schools.



Royal visitors to the Winnipeg General Hospital, Winnipeg, Canada. The king and queen were welcomed by interns, nurses and 400 patients.

Names in the News

Administrators

CHARLES E. VADAKIN, manager, Kahler Hospital, Rochester, Minn., has been appointed administrator of the Doctors' Hospital, Washington, D. C., a 250 bed institution to open Jan. 1, 1940. SENATOR ROBERT A. TAFT of Ohio was the principal speaker at the cornerstone laying ceremonies on July 11. DR. CHARLES STANLEY WHITE, president of the hospital, presided.

MACIE KNAPP of Bloomington, Ill., has been named superintendent of the new municipal hospital to be opened at Clarinda, Iowa, by the middle of August. A graduate of the University of Michigan, Miss Knapp took post-graduate work in hospital administration at the University of Chicago and has had twenty-two years of hospital experience, serving in this capacity in New Jersey, New York and Illinois. She also was engaged in Near East relief work for two years.

MYRTLE LUCKETT, night superintendent at St. Vincent's Hospital, Birmingham, Ala., for the last five years, has been appointed superintendent of Huntsville Hospital, Huntsville, Ala., succeeding VIRGINIA M. WELLS. IDA MEAHEARE of Memphis, Tenn., has been appointed anesthetist at the Huntsville Hospital.

DR. FRANK R. BRADLEY, acting superintendent of Barnes Hospital, St. Louis,

since last April, has been named superintendent to succeed DR. LOUIS H. BURLINGHAM, who resigned because of poor health after twenty-two years in that position. Doctor Bradley is president of the Missouri State Hospital Association and a member of the A.C.H.A.

DR. W. H. GOODRICH, acting superintendent, University Hospital, Augusta, Ga., has been given full administrative control of that institution by the board of trustees, which in a called session gave him power to hire and fire. The only checkrein on the agreement was a request that Doctor Goodrich's activities not conflict with those of DR. G. LOMBARD KELLY, medical director of teaching facilities at the hospital.

THE REV. HORACE TURNER of Billings, Mont., became administrator of the Deaconess Hospital, Spokane, Wash., on July 1. FANNIE FORTH, R.N., who has been acting head since the death of DR. ROBERT WARNER three years ago, will remain as assistant administrator, supervising the technical work of the institution.

E. REID CADDY, former administrative assistant at St. Luke's Hospital, New York, is now the director of the South Baltimore General Hospital, Baltimore.

DR. JOHN H. MARSH has resigned as superintendent of Delaware County Tuberculosis Hospital, Delhi, N. Y.,



THERE are bleaches and . . . bleaches. Some will remove stain and whiten fabrics, but in the process they may also injure them. Other bleaches are safe, but not effective. The real problem is to find a bleach that will do the safest job of whitening and sterilizing your white cotton and linen fabrics.

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WYANDOTTE MICHIGAN

SERVICE REPRESENTATIVES IN 88 CITIES



to become assistant superintendent of Rhode Island State Infirmary, Howard, R. I.

DR. O. E. HARVEY has resigned as superintendent of District Tuberculosis Hospital, Lima, Ohio, effective August 1.

MARY E. CORBITT, assistant superintendent of Jackson Memorial Hospital, Miami, Fla., was elected chairman of the Florida state board of nurses' examiners.

DR. JOSEPH WHALEN, superintendent of the Wyoming State Hospital, Cheyenne, has been reappointed by the state board of charities and reform.

LEONARD E. SCOTT has been chosen superintendent of the Marathon County Home and Hospital, Wausau, Wis., succeeding the late JOHN D. CHRISTIE.

DR. SETH F. H. HOWES, superintendent of the State Hospital for Mental Diseases, Howard, R. I., has resigned from that position. Doctor Howes had requested that he be given greater control of the hospital, which was refused by VINCENT SORRENTINO, director of the state social welfare department. Doctor Howes served as assistant superintendent of the hospital

prior to March 1936 when he was appointed superintendent of the state infirmary. Two months later he was named head of the mental hospital.

Department Heads

MARY E. BRACKETT, R.N., has resigned as director of nursing at George F. Geisinger Memorial Hospital, Danville, Pa., to accept a similar position at the Samaritan Hospital, Troy, N. Y. She will be succeeded at Geisinger Memorial Hospital by RUTH K. MOSER, R.N., formerly connected with Springfield Hospital, Springfield, Mass., who is at present obtaining the master's degree in nursing education.

KATHRYN WALTER, supervisor of the Allentown State Hospital, Allentown, Pa., resigned recently to accept the position of night supervisor of the Homeopathic Hospital, Washington, D. C.

ETTA LUBBERTS, who has been assistant to the director of the school of nursing, Evanston Hospital, Evanston, Ill., for the last two years, will take charge of the nursing school of Methodist Hospital, Omaha, Neb., August 1.

Deaths

DR. J. F. HIGHSMITH, founder of Highsmith Hospital at Fayetteville,

N. C., and first president of the North Carolina Hospital Association, died recently.

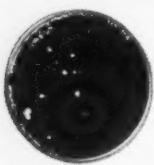
DR. ERNEST COOPER, superintendent of the South Carolina Sanatorium, State Park, S. C., died recently at Columbia Hospital, Columbia, S. C. A crusader in the battle to eliminate tuberculosis in South Carolina, Doctor Cooper, during his twenty-five years of administration, developed South Carolina Sanatorium from one wooden shack to a modern tuberculosis institution of 500 beds.

MINNIE E. HOWE, who was director of nursing and principal of the school of pediatric nursing at Children's Memorial Hospital, Chicago, for ten years, died recently. Memorial services were held in the auditorium of the nurses' home in tribute to her contributions to the advancement of nursing. A scholarship to be known as the Minnie E. Howe Memorial Scholarship also is being established in her memory. This scholarship is to give nurses of the Children's Memorial Hospital opportunity to further their knowledge of nursing education, particularly in the care of children. MARGARET M. INGERSOLL is the acting director of nursing at the hospital.

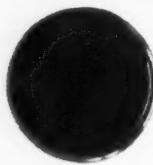
GAUZE MASKS are DANGEROUS

Exhaustive laboratory tests have proved that gauze or linen masks only filter gross particles. They allow millions of bacteria to be blown into an open wound. The same tests prove that

SUR-MASK INSURES ASEPSIS



Culture obtained in surgical routine from nurse wearing gauze mask. Organisms included Staphylococci, Streptococci, Micrococcus catarrhalis.



This plate was made under identical conditions as one at left, except nurse wore Sur-Mask. No growth after 48-hour incubation.



Smoke can easily be blown through gauze or linen masks. Bacteria are constantly being "blown" into operative wounds in same manner.



Even sneezing cannot pass through Sur-Mask. Molded channels control air-circulation, reduce surface contact, making mask cool and comfortable.

Below: Unique construction of Sur-Mask permits perfect vision, and easy speech, yet prevents fogging of glasses. Test Sur-Mask yourself.

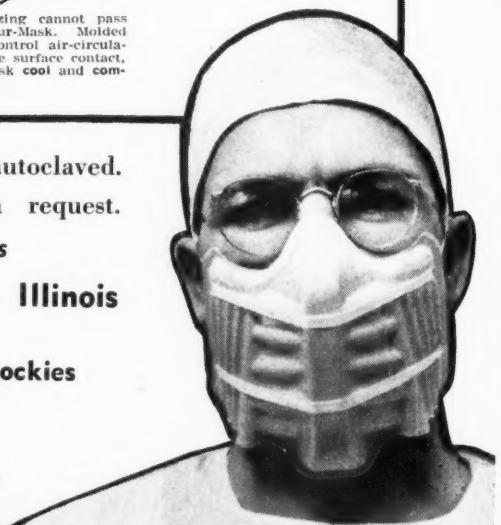
Sur-Mask is made of impermeable pressed pulp . . . can be autoclaved. Economical. Additional information will be furnished on request.

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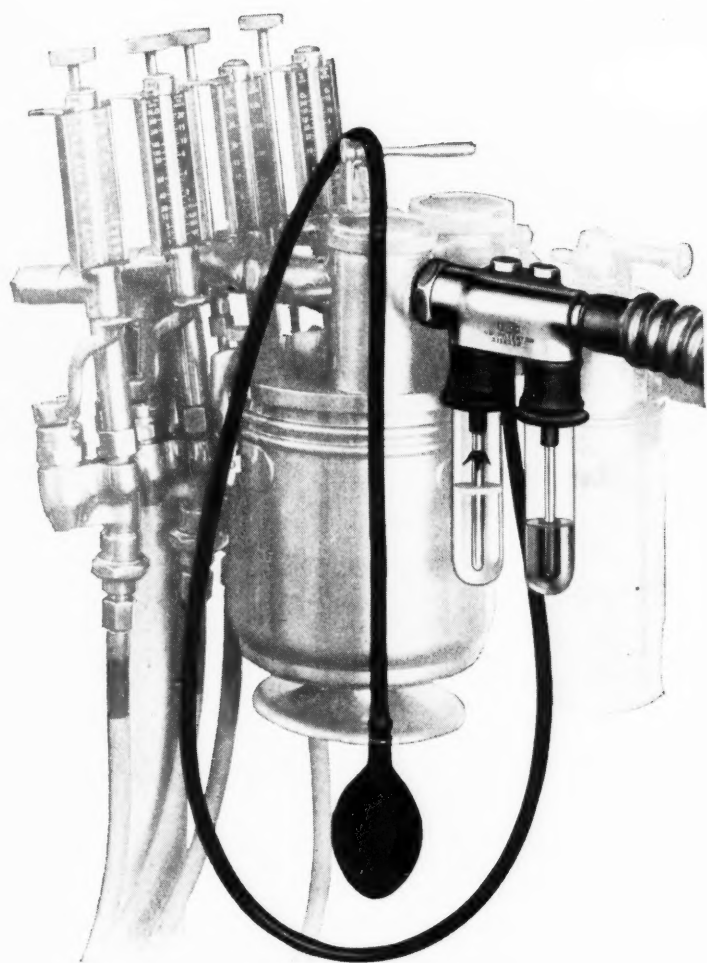
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WARNS ANESTHETIST when soda lime should be changed.

To test gas inspired by patient, simply press bulb. A small amount of mixed gases will pass through the solution, without loss or change in composition, enabling the anesthetist to immediately detect its exact condition by color.

If the soda lime is functioning properly, the Carbon Dioxid will remain within the

allowable limits and no color change will occur. If the soda lime is not removing the Carbon Dioxid properly, the anesthetist is immediately warned by a definite change in color.

As soon as the soda lime charge has been replaced, the color of the solution returns to normal.

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I. H. A. Program, Cont.

(Continued from page 67)

Study Committee XXXIII, Laboratories and Laboratory Requirements: Chairman, Doc. Dr. Vaclav Strimpl, Statni zdravotni ustav, Prague.

Report: Laboratories and Their Requirements.

Study Committee XXXII, Physical Therapy: Chairman, Dr. C. E. Iredell, Surgeon-in-Charge, Actino-Therapeutic Department, Guy's Hospital, London.

Report: Position of Physiotherapists in Relation to Medical Profession.

Study Committee XIXB, Occupational Therapy: Chairman, Prof. Dr. Karlis Barons, Präsident, des Lettischen Roten Kreuzes, Riga, Latvia.

Report: Occupational Therapy.

4:30—6 p.m.

Observation and Study Tours of Toronto Hospitals.

8—10 p.m.

Public Meeting, Convocation Hall, University of Toronto

Honorable Canon H. J. Cody, presiding. Greetings from the International Hospital Association, Dr. Malcolm T. MacEachern, Chicago.

Greetings from the American Hospital Association, Dr. G. Harvey Agnew, Toronto.

"Health and Human Progress," Dr. René Sand, Secretary-General, Ministry of Health, Belgium; Technical Counsellor to the League of Red Cross Societies.

"What Great Britain Is Doing to Improve the Health of the People," W. McAdam

Eccles, Consulting Surgeon, St. Bartholomew's Hospital, London.

"A Health Program for Canada," Dr. Fred W. Routley, National Commissioner, Canadian Red Cross Society, Toronto.

"The Role of the Hospital in Health Conservation," Dr. Hans Frey, Director, Insel Hospital, Bern, Switzerland.

"Voluntary and State Cooperation in Health Conservation," Rt. Rev. Msgr. Maurice F. Griffin, Vice President, Catholic Hospital Association; Senior Trustee, American Hospital Association.

Saturday, September 23

9:30—11:30 a.m.

Reports of Study Committees

Study Committee IV, Accounting and Finance: Chairman, Dr. C. Rufus Rorem, Director, Commission on Hospital Service, American Hospital Association, Chicago.

Report: Interest and Depreciation in Hospital Accounting.

Study Committee XXXV, Productive Sidelines: Chairman, Herrn Bau-Ingenieur Mieczyslaw Kozlowski, Warsaw.

Study Committee XVIII, Hospital Social Service: Chairman, M. le Prof. A. Couvelaire, Directeur de la Clinique Gynécologique et Obstétricale Bandelocque de l'Université de Paris, Paris.

Report: Practical Suggestions for Influencing Patients by Health Instruction While in Hospital.

Study Committee VII, Dietetics: Chairman, Prof. Dr. A. von Soos, Direktor des Instituts für Diätetik der Universität Budapest, Budapest.

Report: Organization of Course in Dietetic Technic and the Establishment of Such an Organization in the Hospital.

Study Committee XIXA, Hospital Libraries: Chairman, Mrs. M. E. Roberts, British Red Cross Society and Order of St. John Hospital Library, London.

Report: Development and Organization of Hospital Libraries and a Survey of Their Present Position and Progress.

Study Committee XXXIX, Centers for Hospital Standards, Information and Research: Chairman, Hjalmar Cederstrom, Ingenior, Stockholm.

Report: Plans and Work of Study Committee XXXIX.

Study Committee XXVIII, Neurology: Chairman, Dr. F. H. Lewy, Hospital of the University of Pennsylvania, Philadelphia.

Report: Management of Head Injuries in the General Hospital—the Neurological, Surgical, Sociological and Medicolegal Aspects of the Problem.

Study Committee XXVII, Psychiatry: Chairman, Dr. Thomas J. Heldt, Physician-in-Charge, Division of Neuropsychiatry, Henry Ford Hospital, Detroit.

Report: Symposium on Schizophrenia.

Study Committee XII, National Hospital Associations: Chairman, Dr. Otto Binswanger, Kreuzlingen, Switzerland.

Report: National Hospital Associations; Their Financing.

Special Council for Study Committees: Chairman, Dr. A. F. Cooney, Secretary, Hospitals' Commission, Dublin.

2—3 p.m.

Meeting of Council of Management.

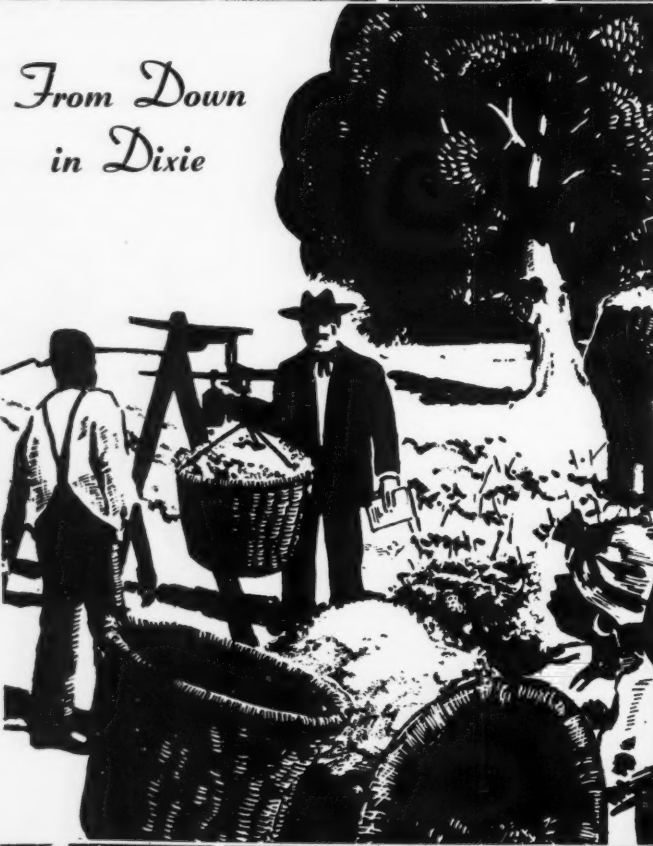
Fifth Plenary Session, 3—5 p.m.

Submission of resolutions by the study committees.

Installation of officers.

Other business.

Official closing.



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Fine Absorbent Cotton,
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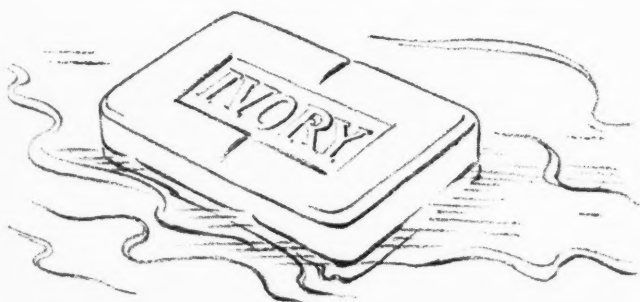
For many, many years in many, many hospitals Ivory Soap has been attending to this all-important factor in patient comfort. Ivory's purity and gentleness—its freedom from perfume and all irritating elements—have made it an ideal soap for bathing patients.

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They came to us and told of the things they ache and long to do, said they wanted opportunity, asked for a chance to pit their minds, their wills and courage against the toughest tasks in medicine and hospitals.

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Around the first part of September, we are moving to beautiful, larger quarters in the Palmolive Building. A definite date will be announced later.

BOOKS ON REVIEW • • •

ECONOMIC ASPECTS OF MEDICAL SERVICES. By Paul A. Dodd and E. F. Penrose. Washington, D. C.: Graphic Arts Press, Inc., 1939. Pp. xxii + 499. \$3.75.

Professors Dodd and Penrose have made the most thorough study thus far of the economics of medicine in a particular state. The California Medical-Economic Survey was initiated by the state medical society in 1934 with a committee of five physicians in charge, an advisory council of social scientists from the chief universities in California and Professor Dodd as the head of the staff, dental and osteopathic advisory committees. It cost \$94,000, \$59,000 coming from public funds and \$35,000 from the California Medical Association.

After the work had been completed and a preliminary report circulated, "resistance on the part of certain members of the association" to its publication appeared. "Financial backing . . . was suddenly withdrawn." It was necessary for the authors to obtain private aid before their full report could see the light. Their comments

on certain issues display some animus, doubtless arising from these experiences.

The study concluded that in this state, with a population of about six millions, there were more than 300,000 persons who at any given time need but are not receiving medical care, and more than 350,000 in the same situation as regards dental service. "This number," says the report, "is sufficiently great to afford an average of some 30 new medical patients and some 60 new dental patients to every licensed physician and dentist in California."

The average family in California was found to spend about $3\frac{1}{2}$ per cent of its total income for medical services, but the families with an income of \$5000 or more a year spent only 2 per cent while those with an income under \$2500 had to tax themselves double that ratio out of less than half the income. On the other side of the picture, half of the general practitioners throughout the state reported net professional incomes of less than \$2200 during 1929, and by 1934 the average income had dropped one third. The amount of free work and of unused time is substantial.

The book recommends substantial changes in the organization of public health work and a compulsory health insurance law, the principles for which are outlined in detail. A law more or less similar to these proposals was considered at the last session of the California legislature.—MICHAEL M. DAVIS.

THE PATIENT AS A PERSON. By G. Canby Robinson. New York: The New York Commonwealth Fund, 1939. Pp. 424. \$3.

By its comprehensive and detailed review of 174 unselected cases admitted to the Johns Hopkins Hospital, this book effectively drives home the importance of considering the patient as an individual. The writer found adverse social conditions in the lives of 80 per cent of the patients; in 66 per cent of the cases these conditions had a definite relation to their illnesses; in 26 per cent, they were considered to be the chief cause of illness.

The cases are grouped largely according to their symptoms and the author points out how, both individually and as groups, these patients were benefited or the reasons why the treatment failed to benefit them.

The book may profitably be read by physicians and social workers.

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In no other country has hospitalization made such progress. This great advance movement has won the admiration of the world.

Buying surgical instruments on price alone, however, affects the high standard of that part of the equipment.

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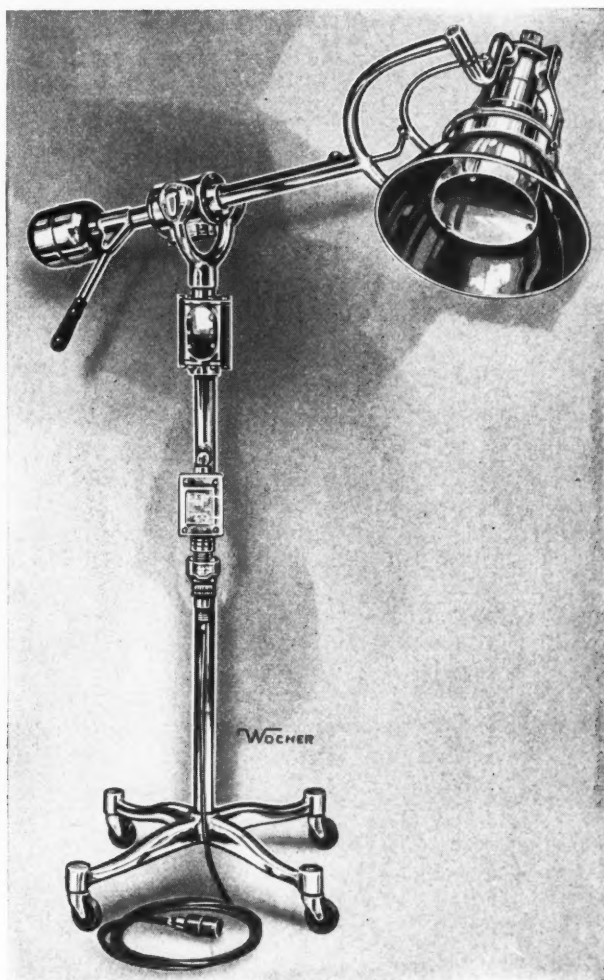
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CINCINNATI

READER OPINION

Hospitals in Java

Sirs:

In answer to your letter, dated April 8, which was received on May 15, I gladly inform you of the following:

The G.C.B.Z. (Central Civil Government Hospital of East Java) is run, without a board, by a superintendent under the supervision of the Department of Public Health.

Every decision is taken by him; in cases of important financial consequence he must obtain the consent of the above mentioned department (e.g. the inspector-in-chief of the public health service at Batavia).

The daily average of the number of indoor patients lies between 750 and 800; that of the outdoor patients, between 650 and 700. Most of them are Asiatics; the ratio is approximately 6 Asiatics to 1 European.

The doctors are partly Europeans and partly Indonesians (e.g. Javanese, Sumatrans, Amboinese, Eurasians). Most of them were graduated and specialized in the Netherlands; all of them are full-

time doctors and officials of the government of the N.E.I. It may interest you to know that many of the Indonesians make fine surgeons and physicians.

Nursing is done by Indonesian and a small number of Chinese and Eurasian nurses. They are educated in one of the three big government hospitals (G.C.B.Z. at Batavia, Semarang and Soerabaia) and are graduated after a practical and theoretical course of four years. They live in nurses' homes on the hospital grounds and work under the supervision of a staff of European nurses, educated and graduated in Holland. The European nurses are specially trained for work in these hospitals.

To the school for midwives are admitted carefully selected trained native nurses; after another two years' course they are graduated and are allowed to practice midwifery all over the country. In remote parts of the archipelago they do some fine practical and educational work. Furthermore, we have a school for dentists; the students work under the supervision of European dental surgeons, qualified in Holland. The quan-

tity of the living material is enviable; many Europeans come here for dental treatment.

The students of the Medical School of the N.E.I. receive their clinical education in the hospital.

The buildings are old but the equipment is up to date: four operating rooms, instruments, x-ray therapy and radium therapy.

It is easily understood that running a hospital like this makes it imperative to keep in touch with modern Western ideas regarding hospital work and organization. Moreover, in 1941, we shall remove into the fine new buildings with a total bed capacity of 1000.

These are the reasons why in my office are found medical periodicals dealing especially with hospital work, building and organization, for example: *Ziekenhuiswezen* (Dutch), *Krankhauswesen* (German), *Nosokomeion* (International), *The MODERN HOSPITAL* (American), *Hospitals* (American) and *The Hospital* (British).

I hope these few lines will be suitable to give you the information you need.

With collegial regards,

Dr. A. Bloch.

Centr. Burg. Ziekeninrichting,
Simpang, Soerabaia,
Java, Dutch East Indies.

AS ONE PHYSICIAN TO ANOTHER...

In Treating Constipation, This is What 9 Physicians Out of 10 Would Say . . .

New habits of elimination, new dietary habits are the basis of most successful treatment. However, in aiding in the re-establishment of such habits, a bland pure mineral oil may often be most helpful. And now, in light of recent studies upon the effects of Vitamin B-1 in the gastro-intestinal tract, this important food factor may be an essential in restoring normal tonus to the neuromuscular mechanism of the intestines.

Both of These Important Aids are Present in Vita Nujol!

VITA NUJOL is a pleasant tasting mineral oil emulsion with pure crystalline Vitamin B-1 added. The concentration of the vitamin is such that the recommended average dose of Vita Nujol contains the average maintenance requirements for an adult (400 International Units).

VITA NUJOL will be found to be helpful not only in the treatment of

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Hospital Executives, Consultants, Trustees, Architects are invited to visit the offices of The MODERN HOSPITAL in Room 1221 of 101 Park Avenue. A special conference room has been arranged for any convenience they might wish. The many exhibits and features of the building will be introduced to them if desired.

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IT'S SAID THAT—

A pictorial presentation of the new laboratories and the manufacturing process of Baxter intravenous solutions has just been published by DON BAXTER, INC., Glendale, Calif. . . . The AMERICAN CAN COMPANY, 230 Park Avenue, New York, has recently issued the 1939 "Canned Food Reference Manual," which is designed to provide reliable information on canning to laymen and also to present technical information to those professions that deal with canned foods. . . . Sanit-Aire wet unit filters, marketed by ENZ-ODR, INC., Green Bay, Wis., eliminate all dirt particles, dust, soot, bacteria, pollen and odors from the air, and are quiet and economical to operate.

The PYRENE MANUFACTURING COMPANY, Newark, N. J., announces a fire extinguisher that requires no chemicals and no annual recharging; it discharges a 40 foot stream of plain water by means of pressure from a carbon dioxide gas cartridge. . . . A new illustrated catalog on the Troy-

Engberg generating sets has been published by TROY ENGINE AND MACHINE COMPANY, Troy, Pa. . . . Production of a silk suture of great tensile strength has been announced by DAVIS & GECK, INC., Brooklyn, N. Y. The suture retains all the smoothness of natural untreated silk while new principles of fabrication make it easy to handle and to tie securely. . . . The all-purpose overbed table introduced by HILL-ROM COMPANY, Batesville, Ind., can be adjusted and used by the patient for eating, reading, dressing, shaving and playing cards, or it can be used as a flower table when removed from the bed.

Built on the principle of the venetian blind, the new Kenwood venetian screen, manufactured by WILL ROSS, INC., Milwaukee, Wis., provides full privacy for the patient without retarding ventilation; it can be closed completely or adjusted to deflect air currents upward, allowing full circulation without subjecting the patient to a direct breeze. . . . The UTILITY ELECTRIC COMPANY, St. Louis, is offering a new model com-

mercial toaster that features an automatic "convey-o-lift" that conveys the bread up through the oven past the guard wires; this eliminates one of the causes of uneven toast. . . . Four modern outstanding types of zeolite water softeners and their principles are discussed in the new bulletin on water conditioning published by the ELGIN SOFTENER CORPORATION, Elgin, Ill.

A new fine-pore cellulose sponge, known as surgeons' "Drybrow" pad, which is worn by surgeons as a sweat pad, is being manufactured by AMERICAN ALLSAFE COMPANY, Buffalo, N. Y. The pad absorbs twenty times its weight in moisture and prevents the possibility of perspiration dripping into an open incision or into the eyes and the eyeglasses of the operating surgeon. . . . The FRANKLIN RESEARCH COMPANY, Philadelphia, announces a completely modernized "40" drop booklet showing exaggerated wax films in evaporated form. The films permit the layman to examine waxes for such characteristics as alkaline content, water resistance and toughness of film.

A Hospital's Reputation Among Laymen . . .



frequently is determined by things that are not directly related to the science of healing, and leaves out of account such things as fine technical equipment and expert professional conduct. It's just human nature. The ex-patient is going to tell his friends whether the meals were good or not; whether his room was cheerful or depressing; whether the furniture was colorful and homelike or drab and ugly.

Nothing will do so much to send a favorable impression of your hospital out to those who are as yet unacquainted with it as to have your rooms, or some of them at least, furnished with HILL-ROM beds, tables, chairs, dressers, etc., built of fine woods finished in beautiful natural grain and color, in designs worthy of the best private residences.

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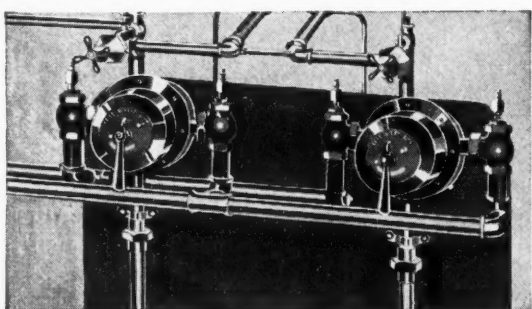
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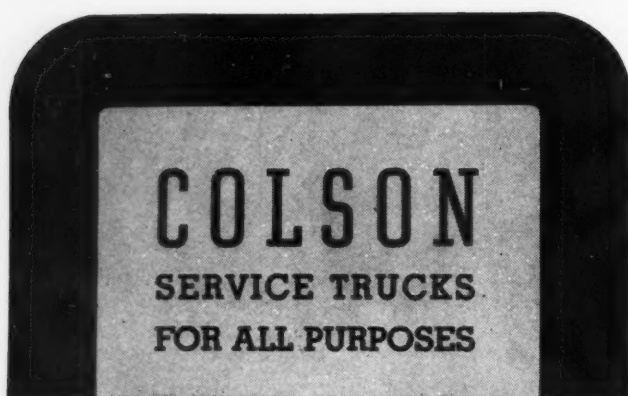


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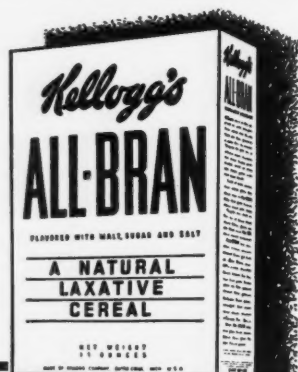
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Serve the individual package



RELAXATIVES

"Objection Sustained!"

• Supererudition on the part of a physician may defeat its own ends. The accuracy of this transcription from an actual court record is attested by the shorthand reporter:

Mr. Worthington: "Doctor, in language as nearly popular as the subject will permit, will you please tell the jury just what the cause of this man's death was?"

Witness: "Do you mean the proxima causa mortis?"

Mr. Worthington: "I don't know, Doctor. I will have to leave that to you."

Witness: "Well, in plain language, he died of an edema of the brain that followed a cerebral thrombosis or possibly embolism that followed, in turn, an arteriosclerosis combined with the effects of a gangrenous cholecystitis."

Juror: "Well, I'll be damned!"

The Court: "Ordinarily I would fine a juror for saying anything like that in court, but I cannot in this instance justly impose a penalty upon you, sir, because the court was thinking exactly the same thing."

Proverbs That Do Not Always Apply to Hospitals

"He that is down need fear no fall."

"Cross the bridge when you come to it."

"All's well that ends well."

"Silence gives consent."

"A prophet is without honor in his own country."

"Dead men tell no tales."

The Week's Gem

(From G. F. S., Toronto)

• The scene was a two bed, bright, airy public ward to which had been admitted an old age pensioner, a woman about to die. Accompanying her was her daughter, who was easily the winner of our monthly contest for the most offensive relative. She ended her tirade of abuse of the accommodation and treatment with a severe condemnation of our failure to recognize the blue blood of the B—B— which flowed through her veins.

An intern, standing by, remembered having seen this daughter in another hospital and volunteered the following model of descriptive statement:

"The only blue blood flowing through her veins was the cyanosis due to taking sulfanilamide for a specific infection."

Too Seriously Speaking

- "The Suicidal Ward"
- "The Traveling Mind"
- "The Cancer Congress"
- "The Diabetic Association"

HOSPITAL MOTHER GOOSE

• *Old King Cole was a merry old soul,
The head of a hospital, he;
For his job was a pipe; he could golf; he could bowl.
"Oh, where is that job?" say we.*

* * *

• *Robin and Richard were two pretty men.
They lay in bed till the clock struck ten.
Merely two interns, without justification,
Absenting themselves from a dull operation.*